DOCUMENT RESUME

ED 143 894 CG 011 656

TITLE Developments in Aging: 1976. Part 1. A Report of the Special Committee on Aging, United States Senate, Pursuant to S. Res. 373, March 1, 1976 Resolution Authorizing a Study of the Problems of the Aged and Aging Together with Minority Views. 95th Congress, 1st Session. Report No. 95-88.

PUB DATE 7 Apr 77

NOTE 285p.; Not Available in hard copy due to marginal legibility of the original document

AVAILABLE FROM Government Printing Office, Washington, D.C.

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.

DESCRIPTORS *Community Involvement; *Economic Disadvantagement; Federal Programs; *Geriatrics; *Gerontology; Legislation; *Older Adults; Rural Farm Residents; Social Responsibility; *State Federal Aid

ABSTRACT

The first part of a report by the Special Committee on Aging of the United States Senate provides additional evidence about the need for far-ranging federal attention to the needs and aspirations of older Americans. A number of difficulties such as special transportation needs in rural areas, contradictions in policies and programs, and disaster relief for the elderly are discussed. However, many positive developments such as actions taken at the State level to increase the variety and support of programs are described. (VG)

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ED143894

95TH CONGRESS
1st Session

SENATE

REPORT
No. 95-88

PART 1

DEVELOPMENTS IN AGING: 1976

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 373, MARCH 1, 1976

Resolution Authorizing a Study of the Problems of the Aged and Aging

TOGETHER WITH

MINORITY VIEWS

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

APRIL 7 (legislative day, FEBRUARY 21), 1977.—Ordered to be printed

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JOHN GUY MILLER, *Minority Staff Director*

(II)

HISTORY

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(Frank Church, chairman of the full committee, and Hiram L. Fong, ranking minority member, were members of all subcommittees, ex officio)

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Subcommittee on Health of the Elderly: Edmund S. Muskie, chairman; Frank E. Moss, Harrison A. Williams, Jr., Edward M. Kennedy, Walter F. Mondale, Vance Hartke, Claiborne Pell, Thomas F. Eagleton, John V. Tunney, Lawton Chiles, Dick Clark, John A. Durkin, Pete V. Domenici, Clifford P. Hansen, Edward W. Brooke, Charles H. Percy, Robert T. Stafford, Glenn Beall, Jr., and Dewey F. Bartlett.

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[1] Under authority of Amendment No. 23 to S. Res. 4, agreed to Feb. 1, 1977, the new permanent Special Committee on Aging was established. Under authority of S. Res. 84, Feb. 11, 1977, new members were named as follows: Frank Church, chairman, Edmund S. Muskie, Lawton Chiles, John Glenn, John Melcher, Dennis DeConcini; Pete V. Domenici, Edward W. Brooke, and Charles H. Percy; to form a ratio of six Democrats to three Republicans.

[2] Amendment No. 23 to S. Res. 4, Reorganization of the Senate Committee System, agreed to Feb. 1, 1977, established the Special Committee on Aging as a permanent, nonlegislative committee under the rules of the Senate. Membership was reduced from 23 to 14 for the 95th Congress and by attrition must begin the 96th Congress with no more than nine members. Grandfathering of present 16 members had been included in establishing Amendment No. 23 but was relinquished on the floor. Service on the committee ended Feb. 1, 1977.

[3] Term of office expired.

[4] Resigned from committee and the U.S. Senate Dec. 31, 1976, to assume the office of Vice President of the United States.

[5] During the executive session on Mar. 4, 1977, the members of the new permanent Special Committee on Aging decided not to establish subcommittees.

4

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., April 1, 1977.

Hon. WALTER F. MONDALE,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 373 agreed to March 1, 1976, I am submitting to you the annual report of the Senate Special Committee on Aging, "Developments in Aging: 1976," Part I.

Publication has been delayed this year by one month because of Senate reorganization and the need for the new membership of this Committee to review the draft report.

Senate Resolution 4, approved by the Senate, February 1, 1977, authorizes this Committee to continue inquiries and evaluations of issues on aging. This pertains not only to those of age 65 and beyond but others who find that advancing years affect their lives in one way or another.

On behalf of the members of the Committee and its staff, I want to extend my thanks to the officers of the Senate for the cooperation and courtesies extended to us.

Sincerely,

FRANK CHURCH, *Chairman.*

SENATE RESOLUTION 373, 94th CONGRESS, 2d SESSION

Resolved, That the Special Committee on Aging, established by S. Res. 33, Eighty-seventh Congress, agreed to on February 13, 1961, as amended and supplemented, is hereby extended through February 28, 1977.[1]

SEC. 2. (a) The committee shall make a full and complete study and investigation of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing, and, when necessary, of obtaining care or assistance. No proposed legislation shall be referred to such committee, and such committee shall not have power to report by bill, or otherwise have legislative jurisdiction.

(b) A majority of the members of the committee or any subcommittee thereof shall constitute a quorum for the transaction of business, except that a lesser number, to be fixed by the committee, shall constitute a quorum for the purpose of taking sworn testimony.

SEC. 3. (a) For purposes of this resolution, the committee is authorized from March 1, 1975, through February 28, 1977, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to hold hearings, (3) to sit and act at any time or place during the sessions, recesses, and adjournment periods of the Senate, (4) to require by subpena or otherwise the attendance of witnesses and the production of correspondence, books, papers, and documents, (5) to administer oaths, (6) to take testimony orally or by deposition, (7) to employ personnel, (8) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel, information, and facilities of any department or agency, and (9) to procure the temporary services (not in excess of one year) or intermittent services of individual consultants, or organizations thereof, in the same manner and under the same condition as a standing committee of the Senate may procure such services under section 202(i) of the Legislative Reorganization Act of 1946.

(b) The minority shall receive fair consideration in the appointment of staff personnel pursuant to this resolution. Such personnel assigned to the minority shall be accorded equitable treatment with respect to the fixing of salary rates, the assignment of facilities, and the accessibility of committee records.

SEC. 4. The expenses of the committee under this resolution shall not exceed $507,000, of which amount not to exceed $20,000 shall be available for the procurement of the services of individual consultants or organizations thereof.

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[1] Agreed to Mar. 1, 1976.

SEC. 5. The committee shall report the results of its study and investigation, together with such recommendations as it may deem advisable, to the Senate at the earliest practicable date, but not later than February 28, 1977. The committee shall cease to exist at the close of business on February 28, 1977.

SEC. 6. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at an annual rate.

PREFACE

Faced by a challenge to its Committee on Aging, the Senate of the United States emphatically decided early in 1977 that the committee would continue.

The issue was raised by a Senate reorganization plan which would have put major responsibility for aging legislation and oversight into a new Committee on Human Resources.

With others, I argued that aging cuts across so many jurisdictions that no single legislative committee could possibly deal with all issues of concern to older Americans and their families.

What was needed, we said, was a continuation of the committee in the form it took when established in 1961 without authority to receive and report bills, but with the clear-cut duty to search out the facts on aging and "put it all together" in presenting information and recommendations for Senate action.

On February 1, 1977—after an intensive effort within the Senate and from outside, including an outpouring of letters from individual older Americans and their organizations—the Senate voted, 90–4, to keep the committee.[1]

That outcome has significance far beyond immediate Senate reorganization issues.

It recognized the *growing* need for special attention to aging in both Houses of Congress.[2] That need is caused partially by the increase in the number of aged and aging Americans, with even more extreme changes in proportions of young and older population expected in the not-too-distant future. It is also caused by the need to take stock of existing Federal programs and agencies for adequacy and effectiveness, all the more so since the new administration has a clear commitment to reorganization of the executive branch as one step toward more responsive and efficient government.

Additional evidence about the need for far-ranging congressional attention to the needs and aspirations of older Americans is provided in the chapters of this report.

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[1] Senator Church, with 50 cosponsors, had introduced an amendment to S. Res. 4, the reorganization plan offered by the Temporary Committee to Study the Senate Committee System. His amendment, modified at the suggestion of supporters of S. Res. 4, gave the Committee on Aging permanent status similar to that of the Small Business and Veterans Committees. One of the compromise features was reduction in size from 16 to 9 members. For present membership, see inside cover of this report. For Congressional Record debate, see pp. S1827 to 1878 in the Feb. 1 issue. Senator Harrison Williams, former chairman of this committee and now chairman of the Committee on Human Resources, argued against assigning the functions of the Committee on Aging to the Human Resources Committee. At hearings by the Senate Rules Committee—of which he is a member—and during Senate floor debate, he argued that issues related to aging cut across so many Senate jurisdictions that only a special, factfinding committee could deal with them adequately.

[2] Representative Claude Pepper, chairman of the House Select Committee on Aging, joined Senator Church in urging continuation of the Senate unit on aging. He said that the House had established its unit in 1974 with the Senate example very much in mind, recognizing the need for a similar nonlegislative approach in that body.

There is, for example, the finding that the number of older persons living in poverty was actually on the increase in the aftermath of the 1974–75 recession. Even more troubling is the possibility that a revision of poverty standards,[3] now under way, could drastically raise this number and provide a more realistic picture of the economic strains facing so many of our elderly citizens, including many who thought that they had planned adequately for their retirement years.

No matter what the official measure of impoverishment finally becomes, however, the day-to-day struggle with the cost of living remains the primary concern of many, if not most, of our elderly population.

That struggle still centers partially around the onslaught of inflation upon social security benefits and other forms of retirement income. In prior reports the committee has made the point that older persons generally spend more of their income than other age groups for major essentials, including health care, housing, food, and transportation.

That situation still holds true, but it has been intensified immensely by the drastic impact of high energy costs. The cruel winter of 1977 has dramatized their predicament: this committee has received information about utility bills which have more than doubled, or about people who spend 15 or 20 percent or even more to heat their living quarters.

Warmer weather could cause forgetfulness about discomfort and outright suffering during the prolonged cold spell, but the Congress simply cannot permit this to occur. This committee—at the suggestion of its new ranking Republican member, Senator Domenici, and in continuation of its ongoing evaluation of Federal policies related to energy needs of older Americans—will soon look intensively into those needs. One question will be: How can we provide not only emergency help but sustained action intended to make the homes of the elderly more secure against the harshness of winter?

Furthermore, how can we alert the Nation to the fact that the energy cost problem can become the last straw for many desperate elderly persons who already are faced by other crucial everyday predicaments:

—Medicare, invaluable as it is, still falls far short of actual need and is weakest where need is often greatest: it still lacks, for example, coverage of out-of-hospital prescription drugs, eyeglasses, and most dental care. The new administration has given a welcome sign of concern about medicare: the Carter budget proposes a freeze on the premium charges. The actual savings will be only a few dollars a year, but the proposal is important because it recognizes that medicare participants have been paying more and more in charges for less and less in coverage. The preceding administration was perfectly willing to let the increases in charges continue. But the proposed freeze would at last draw a line on one of the costs. Additional steps should be taken in similar directions.

[3] For a discussion of poverty levels, including a differing view formulated by the Congressional Budget Office, see pp. 4 to 6 of this report.

—Inherent limitations within medicare are bad enough, but older Americans, in particular, must feel intense bitterness when they read about ripoffs and abuse within that program and also within medicaid. The Senate Committee on Aging, particularly within recent months, has devoted a great deal of attention to fraud in federally assisted health care programs. We've looked into such matters as kickbacks from pharmacies to clinics and nursing homes, so-called "medicaid mills" in big cities, and questionable home health operations in California. We have recognized that our investigations raise serious questions about the prospects for a national health insurance program serving all age groups, but we will continue those investigations for that very reason, as well as for reasons of justice and equity. The question is simple: How can we hope to have national health care for everyone if we can't manage the programs now serving the elderly and the poor? Our hearings have already suggested many roads to reform; we will now press for constructive action, not only *against* wrongdoing, but also *for* health care options that will reduce present overdependence on institutional care.

—Housing costs, intensified by the energy crisis, require close scrutiny by the Senate Committee on Aging. It may well be that in some parts of the Nation older persons are being priced out of the housing market. A major section 202 direct loan program finally was geared up in 1976 to help nonprofit sponsors provide housing for the elderly. This program, however, still suffers from delays and questionable policies in implementation. In addition, it is not sufficient to meet total need and should be buttressed by a variety of other efforts, including broader action by States. Perhaps the best way to alert the entire Nation to the older American housing crisis is to prepare and provide detailed profiles of need in varying locales of the Nation. This committee will explore that possibility.

A number of other difficulties are described in this report: Such matters as recession's continuing effects on older workers, special needs in rural areas, contradictions in transportation policies and programs, and disaster relief for the elderly. But many of the pages tell of positive developments as well. For example, one section describes the dramatic increase in educational opportunities for the so-called "nontraditional"—in this case, older—person. Another section describes encouraging actions taken at the State level to increase the variety and support of programs for the elderly.

So it goes in aging: a very mixed record of progress and problems. Last year's report by this committee suggested that perhaps the time had come for a "midway" look at national achievements and shortcomings on aging made since the 1971 White House Conference on Aging. The thought was that such a conference, held halfway through the decade which usually intervenes between such conferences, would be timely and useful. But another course is also open: to start planning in the very near future for a White House Conference on Aging

in 1980 or 1981. If we begin early enough, we can insist on having the facts that will be needed to judge how well this Nation is doing, and what more it needs to do, for the well-being of older Americans. I am preparing legislation calling not only for a conference, but for intensive preparations which can also be closely related to executive branch reorganization proposals. Next year, when this report is again issued, I hope that I can report to you that this effort is well underway.

FRANK CHURCH,
Chairman, Special Committee on Aging.

CONTENTS

	Page
Letter of transmittal	v
Senate Resolution 373, 94th Congress, 2d session	VII
Preface	IX
Every Tenth American	XVII
Recent State trends in the older population, 1970–75	XXIII
Chapter I.—What next steps on income?	1
I. How far short of adequacy is social security now?	2
New retired couples budget	3
II. The meaning of the new poverty figures	4
A. The near poor	5
B. Shortcomings of present procedures for determining poverty	5
C. Congressional Budget Office report	6
III. What does SSI buy today?	6
A. Adequacy of SSI	7
B. Steps to improve SSI	9
IV. Next steps toward social security and SSI adequacy	10
A. Social security	10
B. Supplemental security income	11
V. Next steps toward social security soundness in financing	14
A. Carter versus Ford proposals	15
B. Ways and Means Committee and the Hsiao panel recommendations	16
C. Long-range considerations	17
D. Termination of social security coverage by State and local governments	18
VI. The compelling case for an independent Social Security Administration	20
Findings and recommendations	21
Chapter II.—Health costs and problems in medicaid and medicare	23
I. Health care costs and the elderly	23
A. Additional costs in 1976	25
B. Opposition to new increases	25
II. Fraud and abuse: More costs, less service	26
A. Clinical laboratories	26
B. Boarding homes	27
C. Physician fraud	28
D. Medicaid mills	29
E. State and Federal prosecutors	31
III. Mistaken priorities?	33
A. Home health—limited progress	34
B. Adult day facilities	36
IV. National health insurance: First steps	38
A. The NCSC proposal	39
B. The Ribicoff-AARP approach	39
C. Another blueprint for action	39
D. Rural initiatives	40
Findings and recommendations	42
Chapter III.—The Federal role in upgrading nursing homes	43
I. The growth of nursing homes	43
II. The subcommittee reports	44
Introductory Report—"Nursing Home Care in the United States: Failure in Public Policy"	44
Supporting Paper No. 1—"The Litany of Nursing Home Abuses"	44

Chapter III.—The Federal role in upgrading nursing homes—Continued
II. The subcommittee reports—Continued
Page
Supporting Paper No. 2—"Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks" 44
Supporting Paper No. 3—"Doctors in Nursing Homes: The Shunned Responsibility" 45
Supporting Paper No. 4—"Nurses in Nursing Homes: The Heavy Burden (The Reliance on Untrained and Unlicensed Personnel)" 45
Supporting Paper No. 5—"The Continuing Chronicle of Nursing Home Fires" 45
Supporting Paper No. 6—"What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care" 46
Supporting Paper No. 7—"The Role of Nursing Homes in Caring for Discharged Mental Patients" 46
Supporting Paper No. 8—"Access to Nursing Homes by U.S. Minorities" 47
Supporting Paper No. 9—"Profits and the Nursing Home: Incentives in Favor of Poor Care" 47
III. Progress toward implementing the recommendations of the subcommittee's reports 47
A. Lack of a policy with respect to long-term care 47
B. Financial incentives in favor of poor care 48
C. Increasing physician training 49
D. Training for nurses and other personnel 49
E. Proposals to help nursing homes upgrade 50
F. New standards needed 50
G. The need for increased enforcement of standards 51
Summary 52
Chapter IV.—Housing: The desperation level rises 53
I. Housing—the heavy burden 54
Other forms of help 56
II. The limited Federal spectrum 56
A. Section 202: Closer to reality 56
B. Public housing—will it serve the elderly? 57
C. Section 8: Still under fire 58
D. HUD reorganization 59
E. Limitations in supportive services 59
F. Management and training 62
III. The SRO community 64
IV. The rural community 65
Findings and recommendations 66
Chapter V.—Steps toward an aging network 67
I. The Older Americans Act 68
A. Funding increases 68
B. Program progress in title III 69
C. Evaluation of title III 72
D. Program progress in title VII 73
E. Evaluation of title VII 75
F. Emergence of title V senior centers 76
II. The second year of title XX 77
A. Title XX problems 78
B. Coordination of title XX and other service programs 79
III. Other sources of funding 81
A. General revenue sharing 81
B. Community development block grants 83
Findings and recommendations 84
Chapter VI.—Recession's continuing effects on older workers 85
I. The recession's continuing victim 85
II. The legislative victories 89
Findings and recommendations 92
Chapter VII.—Transportation: Contradictions in strategy 93
I. The Administration on Aging 93
II. UMTA resistance to S. 662 94
Rural needs 94
III. Continued delays in the section 16(b)(2) program 94

Chapter VII.—Transportation: Contradictions in strategy—Continued	Page
IV. Retreat on Transbus	95
V. UMTA's paratransit policy	98
The taxi project	99
VI. Local programs	99
Findings and conclusions	101
Chapter VIII.—Steps toward an aging research and training strategy	102
I. NIA: Present and future	102
A. NIA progress in 1976	102
B. Future directions	103
C. Interest in geriatrics as a specialty	105
II. Center for studies of mental health of the aging	107
A. Research objectives	107
B. Training and manpower	107
C. Committee on Mental Health and Illness of the Elderly	108
III. Training and research efforts of AoA	109
A. Training grants	109
B. Research grants	112
C. Multidisciplinary centers of gerontology	113
Findings and recommendations	117
Chapter IX.—The Nation's rural elderly	118
Needs of the rural elderly	119
A. Transportation and the rural elderly	119
B. Housing and the rural elderly	120
C. Health services and the rural elderly	121
Findings and recommendations	123
Chapter X.—A call for action on crime	124
I. The statistical base	124
II. Legislative initiatives	125
A. The Crime Control Act of 1976	125
B. Future legislative directions	126
III. New York City—an appalling siege	126
A. The response	127
B. Community concern and community action	130
Chapter XI.—Areas of continuing or emerging concern	132
I. Minority concerns	132
A. Major actions affecting elderly blacks	136
B. Significant steps for older native Americans	138
C. Increased activity by Spanish-speaking elderly	141
D. The Pacific-Asian elderly research project	142
E. Looking ahead toward the 1985 mid-decade census	143
Conclusions	143
II. Administration of SSI	143
III. Utility costs	147
A. The FEA bill—a forward step	148
B. The FPC natural gas price increase	150
C. Deregulation of other fuels	151
D. FAC's: Invisible inflation	151
E. Other developments	152
IV. Consumer product safety and the elderly	153
A. Implementing the Church amendment	153
B. Setting priorities for safety standards	154
V. Prescription drug prices	155
A. The importance of drugs to the elderly	155
B. The Supreme Court decision	155
C. Federal Trade Commission action	156
D. Other activities	156
E. The MAC program	156
VI. Hearing aids	156
A. FDA action	157
B. FTC action	157
VII. FTC actions on funerals	157
VIII. Implementing the credit law	161

	Page
Chapter XI.—Areas of continuing or emerging concern—Continued	
IX. Architectural barriers: Stricter enforcement, new regulations	162
A. Congress strengthens the Barriers Act	162
B. A & TBCB: Membership and activities	163
C. New Tax provisions concerning barriers	164
D. Office for Civil Rights responsibilities	164
E. New developments in transportation barriers	165
F. A barrier-free future?	165
X. The Tax Reform Act and the elderly	166
A. Major changes affecting the elderly	166
B. An Older Americans Tax Counseling Assistant Act	168
Findings and recommendations	169
XI. Education for older persons	169
A. Community education	170
B. Lifetime Learning Act	171
XII. ERISA: Progress on pensions	171
A. ERISA's regulatory framework: The record	172
B. Reporting and disclosure: Burdensome requirements?	173
C. An appraisal and a look forward	174
XIII. Disaster assistance for the elderly victims	175
A. Federal assistance	175
B. Relationship of disaster assistance to SSI	176
Chapter XII.—Activities at the State level	178
I. Developments in State agencies on aging	178
A. Changes in status during 1976	178
B. Increased responsibility	179
C. State offices on aging budgets	180
D. Title XX agreements	180
II. Reports of innovative programing	181
A. Legal services	182
B. Health programs	182
C. Community-based services	182
D. A comprehensive State plan	184
III. Legislative initiatives	185
A. Tax relief	185
B. Consumer protection	185
C. Community services	188
IV. Activities of national organizations	189
A. Council of State Governments	189
B. U.S. Conference of Mayors	189
C. National Association of Counties	190
Chapter XIII. Improving legal representation for older Americans	191
I. Legal Services Corporation	192
II. Administration on Aging	192
III. Committee on Aging hearings	193
IV. How an "advocacy center" works	197
V. Group prepaid legal services	198
Summary of findings and recommendations	198
Chapter XIV. Midway between White House Conferences on Aging?	199
I. Income in 1971 and 1976	199
II. Health in 1971 and 1976	201
III. The Older Americans Act in 1971 and 1976	202
IV. Housing in 1971 and 1976	204
V. Employment in 1971 and 1976	205
VI. Elderly minority groups in 1971 and 1976	206
VII. Legal services in 1971 and 1976	207

MINORITY VIEWS

Minority views of Messrs. Domenici, Brooke, and Percy 209

INDEX

Index—hearings and reports, 1976 223

EVERY TENTH AMERICAN[1]

Two hundred years ago, when we declared our independence, the colonies had a total population estimated at about 2.5 million. Virginia was the most populous with about 0.5 million. Pennsylvania was next with about 0.3 million. Then came North Carolina, Massachusetts, Maryland, New York, and Connecticut, ranging down in that order to about 0.2 million, with the remaining colonies following. Life expectancy at birth was probably about 38 or 39 years so that the older population numbered about 50,000—or 2 percent of the total.

By 1900, there were 3 million older Americans—those aged 65 and over (65-plus)—comprising 4 percent of the total population, or every 25th American. As of mid-1975, 22.4 million older persons made up better than 10 percent of the over 213 million total resident population—or every 10th American. (In mid-1976, 22.9 out of 214.6 million, or 10.7 percent.)

In 1975, the largest concentrations of older persons—12 percent, or more of a State's total population—occurred in 9 States: Florida (16.1 percent), Arkansas (12.8 percent), Iowa (12.7 percent), Kansas, Missouri, and Nebraska (all three at 12.6 percent), South Dakota (12.5 percent), Oklahoma (12.3 percent), and Rhode Island (12.2 percent).

California and New York each had more than 2 million older people and Pennsylvania, Florida, Texas, Illinois, and Ohio each had more than 1 million.

Almost one-fourth of the Nation's older population lived in just three States (California, New York, and Pennsylvania). Adding five more States (Florida, Texas, Illinois, Ohio, and Michigan) brings the eight-State total equal to almost half the older people in the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, Wisconsin, North Carolina, Tennessee, Minnesota, Georgia, Virginia, and Alabama—a total of 19) to account for just under three-fourth of the older population and an additional 11 (a total of 30) to include 90 percent. The remaining 10 percent of the 65-plus population lived in the remaining 21 States (including the District of Columbia).

What is this population like, and how does it change?

GROWTH IN NUMBERS

During the 70 years betwen 1900 and 1970 (the last census), the total population of the United States grew to almost three times its

[1] Prepared by Herman B. Brotman, consultant to the Special Committee on Aging, U.S. Senate, and former assistant to the Commissioner on Aging, Department of Health, Education, and Welfare. Data for somewhat later periods for some subjects will become available after January 1977, when this analysis was prepared, but any significant changes in relationships are exceedingly unlikely.

size in 1900 while the older part grew to almost seven times its 1900 size—and is still growing faster than the under-65 portion. Between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population (a further 15 percent versus 6 percent in 1970–76).

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona, Florida, Nevada, Hawaii, and New Mexico, in each of which the 65-plus population increased one-third or more. These five States and Alaska were the fastest growing in 1970–75 as well. Florida, with considerable in-migration of older persons, had the highest proportion of older people, 14.5 percent in 1970 and 16.1 percent in 1975. In 1975, California became the State with the largest number of older people, 2,056,000, outnumbering New York (2,030,000) which was first in 1970.

TURNOVER

The older population is not a homogeneous group nor is it static. Every day approximately 5,000 Americans celebrate their 65th birthday; every day approximately 3,600 persons aged 65-plus die. The net increase is about 1,400 a day or 500,000 a year but the 5,000 "newcomers" each day are quite different from those already 65-plus and worlds apart from those already centenarians who were born during or shortly after the Civil War.

AGE

As of mid-1976, most older Americans were under 75 (62 percent); one-half were under 73; and more than one-third (36 percent) were under 70. Between 1970 and 1976, the population aged 65 through 74 increased 14 percent but the population aged 75-plus increased 16 percent. Close to 2 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available but well over 7,000 persons who produced some proof of age are 100-plus and receiving social security benefit payments.

HEALTH STATUS AND UTILIZATION

In household interviews in a national sample of the noninstitutional population in 1973, over two-thirds (68 percent) of the older persons reported their health as good or excellent as compared with others of their own age. Some 22 percent reported their health as fair and some 9 percent as poor. Minority group members, residents of the South, residents of nonmetropolitan areas, and persons with low incomes were more likely to report themselves in poor health.

Assuming all older people in institutions are, by definition, in poor health, a total of 14 percent of all older people consider themselves in poor health.

The most frequently reported chronic conditions are: arthritis (38 percent), hearing impairments (29 percent), and vision impairments, hypertension, and heart conditions (each about 20 percent).

While over 80 percent of the noninstitutional older population reported some chronic condition, less than 18 percent said that such chronic condition limited their mobility. Some 5 percent were con-

fined to the house (but only slightly over 1 percent were bedridden); almost 7 percent needed help in getting around (less than 2 percent needed the help of another person and less than 5 percent needed an aid like a cane, walker, or wheelchair); and almost 6 percent could move around alone, but with some difficulty.

Older people are subject to more disability, see physicians 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Still, some 83 percent reported no hospitalization in the previous year.

Of the 960,300 older people in nursing homes at the time of the 1973–74 study, 17 percent were aged 65–74, 40 percent were 75–84, and 43 percent were 85-plus (in the total older population, the percentages are 62, 30, and 8); 72 percent were women (70 in the total); 69 percent were widowed, 15 percent single, and 12 percent married; and 95 percent were white. Of every 100 admissions to the nursing homes, almost 40 came from their own private residences (only 13 had been living alone), 36 came from general hospitals, 14 from other nursing homes or other facilities, and the rest came primarily from mental institutions and boarding homes.

Preliminary estimates for fiscal year 1975 show per capita health care costs for older Americans came to $1,360, or 3.6 times the $375 spent for each under-65 person: $603 went for hospital care, $342 for nursing home care, $218 for physician services, $118 for drugs, $24 for dentists' services, and $55 for all other items. Older people represent some 10 percent of the population but account for over 29 percent of total personal health care expenditures ($30.4 billion out of $103.2 billion). Of the costs for older persons, about $892 of the $1,360 total (about two-thirds) came from all public programs at all levels; medicare covered 42 percent.

Comparison of the sources of the payments on a per capita basis over the last 10 years shows the following:

	Total	Direct out-of-pocket	Third-party payments			
			Total	Government	Private health insurance	Philanthropy and industry
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1975	375	128	247	108	132	6
65 plus:						
1966	445	237	208	133	71	5
1975	1,360	390	970	892	73	5
Distribution (percent):						
Under 65:						
1966	100	51.1	48.9	19.4	27.3	2.2
1975	100	34.2	65.8	28.8	35.3	1.7
65 plus:						
1966	100	53.2	46.8	29.8	15.9	1.1
1975	100	28.7	71.3	65.6	5.4	0.4

PERSONAL INCOME

Older persons have half the income of their younger conuterparts. In 1975, half of the families headed by an older person had incomes of less than $8,057 ($14,698 for families with under-65 heads); the median income of older persons living alone or with nonrelatives was

$3,311 ($6,460 for younger unrelated individuals). Some 3.3 million, or a sixth of the elderly, lived in households with incomes below the official poverty threshold for that kind of household. This is a considerable improvement over the 4.7 million or quarter of the elderly in 1970 and results primarily from the increases in social security benefits. Women and minority aged are heavily over-represented among the aged poor. Many of the aged poor became poor after reaching old age because of the half to two-thirds cut in income from earnings that results from retirement from the labor force. About 43 percent of the aged couples could not afford the costs of the theoretic retired couple budget prepared by the Bureau of Labor Statistics for a modest but adequate intermediate standard of living ($6,041 in autumn of 1974).

EXPENDITURES FOR CONSUMPTION

Older Americans spend proportionately more of their income on food, shelter, and medical care and less on other items in a pattern generally similar to that of other low-income groups. Persons living on fixed incomes are hit hard by price inflation and command little potential for personal adjustment of income. Even formulas that adjust retirement payments for changes in price indices are of only partial assistance since they do not provide the increase until well after the fact and older people have little in savings to carry them over until income levels are increased to catch up.

LIFE EXPECTANCY

Based on death rates in 1974, average life expectancy at birth was 71.9 years, 68.2 for males but close to 8-years longer or 75.9 for females. At age 65, average remaining years of life were 15.6, 13.4 for men but 4 years longer or 17.5 for women. The 27-year increase in life expectancy at birth since 1900 results from the wiping out of most of the killers of infants and of the young—little improvement has occurred in the upper ages when chronic conditions and diseases become the major killers. Many more people now reach age 65 but, once there, they live only 3.7 years longer than did their ancestors who reached that age in the past.

SEX RATIOS

As a result of the yet unexplained longer life expectancy for females, most older persons are women—13.6 million as compared with 9.4 million men in mid-1976. Between ages 65 and 74, there are 130 women per 100 men; after 74, there are 173. In the 85-plus group, there are 213 women for every 100 men. The average for the total 65-plus population is 145 women per 100 men (see "Projections," below).

MARITAL STATUS

In 1976, most older men were married (7 million or 77 percent) but most older women were widows (6.7 million or 53 percent). There are 5.5 times as many widows as widowers. Among 75-plus women, almost 70 percent were widows. Of the married 65-plus men, almost 40 percent have under-65 wives. In 1972, among the 2.3 million marriages of persons of all ages, there were about 20,200 brides and twice as many, 40,400, grooms aged 65-plus. For almost 6 percent of these older brides

and grooms, it was a first marriage; for the rest, it was a remarriage, mostly after previous widowhood. The marriage rate for 65-plus widows was 2.2 per 1,000 but 18.4 per 1,000 for widowers.

EDUCATIONAL ATTAINMENT

In 1975, half of the older Americans had not completed 1 year of high school while the median for the 25–64 age group was high school graduation. About 2.3 million older people were "functionally illiterate," having had no schooling or less than 5 years. About 8 percent were college graduates.

LIVING ARRANGEMENTS

In 1976, more than 8 of every 10 older men, but only 6 of every 10 older women, lived in family settings; the others lived alone or with nonrelatives except for the less than 1 in 20 who lived in an institution (which jumps to 1 in 5 in the 85-plus age group). About three-quarters of the older men lived in families that included the wife but only one-third of the older women lived in families that included the husband. More than a third of all older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1974, a somewhat smaller proportion of older than of younger persons lived in metropolitan areas (64 versus 69 percent). Within the metropolitan areas, however, most (51 percent) of the older people lived in the central city while most (57 percent) of the under-65 lived in the suburbs. The aging of the suburbs will soon bring a reversal with proportions and problems for older persons similar to those in central cities.

VOTER PARTICIPATION

In the 1976 elections, older people were 15 percent of the 18-plus voting age population but cast 16 percent of the votes. Some 62 percent of the older population voted, a higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher proportion of men than of women voted, but women still outnumbered the men.

MOBILITY

In the March 1975 household survey, 20 percent, or 4.2 million, of the persons then aged 65-plus reported that they had moved from one residence to another in the 5-year period since March 1970. Some 12 percent moved within the same county, 4.1 percent moved to a different county in the same State and only 3.9 percent moved across a State line. The extent of interstate movement seems larger because such migration tends to flow toward a very small number of States—Florida, Arizona, and Nevada.

EMPLOYMENT

In 1976, about 20 percent of 65-plus men (1.8 million) and 8 percent of 65-plus women (1.1 million) were in the labor force with con-

centrations in three low-earnings categories: part time, agriculture, and self-employment. Unemployment ratios were low due partly to the fact that discouraged older workers stop seeking jobs and are not counted as being in the labor force. For those remaining actively in the labor force and counted as unemployed, the average length of unemployment was greater than for younger workers.

AUTOMOBILE OWNERSHIP

As is true for most major household appliances, ownership of automobiles by older households is considerably below that of households with younger heads but a good part of the explanation rests with income level rather than age, health, or choice. A 1972 survey shows the lowest proportion of households owning one or more cars was for those with 65-plus heads (58 percent) and the highest was for those with 35- to 44-year-old heads (88 percent). However, only among the households with under $5,000 annual income was there a decrease in automobile ownership with advancing age. In the over $5,000 per year income households, there was practically no difference by age. Some 92 percent of elderly households with $15,000-plus incomes owned at least one automobile.

PROJECTIONS TO 2000

Projections of the size of the population based on an ultimate completed cohort fertility rate of 2.1—an ultimate level of 2.1 children per woman—no change in net migration, and no new major medical "cures," show the following:

[Numbers in thousands]

Year	Both sexes		Female		
	Number	Percent of all ages	Male	Number	Per 100 men
1975	22,400	10.5	9,172	13,228	144
1980	24,523	11.0	9,914	14,609	147
1985	26,659	11.4	10,684	15,975	150
1990	28,933	11.8	11,518	17,415	151
1995	30,307	11.9	11,995	18,311	153
2000	30,600	11.7	12,041	18,558	154

These averages, however, mask significant differences between age and color groupings as follows:

Percent increase, 1975 to 2000

Group	Both sexes	Men	Women
Total:			
65 plus	37.0	31.6	40.8
65 to 74	23.0	22.6	23.4
75 plus	60.0	49.2	66.4
White:			
65 plus	33.5	28.5	36.9
65 to 74	18.8	19.0	18.6
75 plus	57.3	46.8	63.3
Black:			
65 plus	63.0	56.1	67.9
65 to 74	54.7	52.1	56.8
75 plus	79.4	64.7	88.6

The change in "burden" on the so-called productive-age population (18 to 64) as measured by a gross dependency ratio is as follows:

Year	Number aged under 18 per 100 aged 18–64	Number aged 65-plus per 100 aged 18–64	Total
1970	61.1	17.6	78.7
1975	53.0	17.9	70.9
2000	44.2	19.0	63.2

Recent State Trends in the Older Population, 1970–75

Between 1970 and 1975, the Nation's older population (aged 65-plus) increased from 20 to 22.4 million at a rate much faster than was true for the under-65 population (12 percent versus 4 percent). This was an acceleration of the faster rate of growth of the 65-plus population between 1960 and 1970 (21 percent versus 13 percent).

These National trends, however, represent the averaging out of a variety of separate State trends. Details are presented in the accompanying analytical tables.

PROPORTION OF POPULATION AGED 65-PLUS

For the Nation as a whole (the 50 States and the District of Columbia), the proportion of the total population aged 65-plus rose from 9.8 to 10.5 percent. In two States, the proportion fell as the under-65 population grew faster than the older population (Colorado, 8.5 to 8.3 percent, and Wyoming, 9.1 to 8.8 percent). In one State, the proportion remained unchanged (New Hampshire at 10.6 percent) and in two States the gain was only 0.1 percentage points over the 5-year period (Idaho, 9.5 to 9.6, and Montana, 9.9 to 10.0). In the remaining 46 States, the gains ranged from at least 0.2 percentage points to 1.3 in Connecticut and 1.6 in Florida.

In 1975, three States were at the U.S. average of 10.5 percent (Alabama, New Jersey, and Tennessee), 21 were within 1 percentage point of the U.S. average (11 between 9.5 and 10.4 and 10 between 10.6 and 11.5); 13 were between 1 and 2 percentage points away from the average (7 between 8.5 and 9.4 and 6 between 11.6 and 12.5) and 14 were 3 or more percentage points away (8 at less than 8.5 and 6 at more than 12.5).

SUMMARY: PERCENT OF STATE'S POPULATION AGED 65-PLUS, 1975

Under 8.5 (8)—Alaska, Colorado, Hawaii, Maryland, Nevada, New Mexico, South Carolina, Utah.

8.5–9.4 (7)—Delaware, Georgia, Louisiana, Michigan, North Carolina, Virginia, Wyoming.

9.5–10.4 (11)—Arizona, California, Connecticut, District of Columbia, Idaho, Illinois, Indiana, Montana, Ohio, Texas, Washington.

10.5 (3)—Alabama, New Jersey, Tennessee.

10.6–11.5 (10)—Kentucky, Massachusetts, Minnesota, Mississippi, New Hampshire, New York, North Dakota, Oregon, Vermont, Wisconsin.

11.6–12.5 (6)—Maine, Oklahoma, Pennsylvania, Rhode Island, South Dakota, West Virginia.

Over 12.5 (6)—Arkansas, Florida, Iowa, Kansas, Missouri, Nebraska

Variations in the relative rates of increase changed the rankings of the States between 1970 and 1975. While 11 States maintained the same rank number in 1975 as in 1970, 18 States dropped from one through eight (Idaho) and 22 rose from one through seven (Alabama). In 1975, the largest concentrations of older persons—12 percent or more of a State's total population—occur in nine States: Florida (16.1), Arkansas (12.8), Iowa (12.7), Kansas, Missouri, and Nebraska (all three at 12.6 percent), South Dakota (12.5), Oklahoma (12.3), and Rhode Island (12.2).

DISTRIBUTION AMONG THE STATES

The older population tends to be distributed among the States in the same pattern as the total population except that there is a slightly greater concentration of older persons in some of the larger States. In the rank table, at the points where the States in the total population and the 65-plus population columns match exactly, the percentages are as follows:

	All ages		65 plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	9.9	9.9	9.2	9.2
New York	8.5	18.4	9.1	18.3
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.8	48.2	31.0	49.3
New Jersey	3.4	51.6	3.4	52.7
Massachusetts	2.7	54.3	3.0	55.7
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, Louisiana, Alabama, Washington, Kentucky, Connecticut, Iowa, South Carolina, Oklahoma, Colorado, Mississippi, Oregon, Kansas, Arizona, Arkansas, West Virginia	39.4	93.7	38.4	94.1
Nebraska	.7	94.4	.9	95.0
Utah, New Mexico, Maine, Rhode Island	2.0	96.4	1.9	96.9
Hawaii, Idaho, New Hampshire, Montana, District of Columbia, South Dakota, North Dakota	2.4	98.8	2.2	99.1
Nevada, Delaware, Vermont	.8	99.6	.6	99.7
Wyoming	.2	99.8	.2	99.9
Alaska	.2	100.0	.1	100.0

In 1975, California became the State with the largest number of older people (2,056,000), outnumbering New York (2,036,000) for the first time. The two States account for almost 1 in every 5 persons aged 65-plus in the United States. Five additional States (Pennsylvania, Florida, Texas, Illinois, and Ohio) each had more than 1 million older people and the seven States together contained almost half of the total older population (10,187,000 out of 22,400,000).

Stated another way, almost a quarter of the Nation's older population lives in just three States (California, New York, Pennsylvania). Adding five more (Florida, Texas, Illinois, Ohio, Michigan) brings the eight-State total equal to almost half the older people in the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, Wisconsin, North Carolina, Tennessee, Minnesota, Georgia, Virginia, Alabama—a total of 19) to account for just under three-quarters of the older population and an additional 11 (a total of 30) to include 90 percent. The remaining 10 percent of the 65-plus population lives in the remaining 21 States.

RESIDENT POPULATION AGED 65 PLUS, BY STATE, 1970 AND 1975

State	Number (thousands)		Percent increase		Percent of all ages		State rank[2]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1975	1960–70	1970–75	1970	1975	1970	1975	1960–70	1970–75	1970	1975
Total, 51 "States"	19,972	22,400	21.1	12.2	9.8	10.5						
Alabama	324	378	24.7	16.6	9.4	10.5	21	19	16	13	[3]30	[3]23
Alaska	7	9	27.9	32.4	2.3	2.6	51	51	11	4	51	51
Arizona	161	223	79.0	38.6	9.1	10.0	35	32	4	2	[3]34	[3]29
Arkansas	237	271	22.0	14.5	12.3	12.8	28	28	21	19	[3]3	2
California	1,792	2,056	30.9	14.8	9.0	9.7	2	1	9	16	36	34
Colorado	187	210	18.8	12.3	8.5	8.3	33	34	24	24	38	[3]44
Connecticut	288	321	19.1	11.7	9.5	10.4	26	26	23	26	[3]27	[3]26
Delaware	44	50	22.6	14.7	8.0	8.6	48	48	20	[3]17	[3]42	42
District of Columbia	70	71	2.4	1.0	9.3	9.9	41	45	51	51	[3]32	[3]32
Florida	985	1,347	78.2	36.7	14.5	16.1	7	4	2	3	1	1
Georgia	365	430	26.4	17.7	8.0	8.7	17	17	15	10	[3]42	41
Hawaii	44	57	51.3	29.6	5.7	6.6	47	46	4	5	50	50
Idaho	67	79	16.3	17.2	9.5	9.6	44	42	29	12	[3]27	35
Illinois	1,089	1,153	12.2	5.9	9.8	10.4	4	6	40	[3]47	24	[3]26
Indiana	492	531	10.8	8.0	9.5	10.0	12	12	[3]45	[3]40	[3]27	[3]29
Iowa	349	364	6.9	4.2	12.4	12.7	19	22	49	49	2	3
Kansas	265	285	10.8	7.4	11.8	12.6	27	27	[3]45	43	7	[3]4
Kentucky	336	368	15.1	9.6	10.4	10.2	20	20	35	[3]31	21	[3]20
Louisiana	305	346	27.0	13.4	8.4	9.1	23	23	12	23	[3]39	37
Maine	114	125	7.6	9.6	11.5	11.8	36	36	48	[3]31	9	10
Maryland	298	340	32.3	14.0	7.6	8.3	25	24	8	21	45	[3]44
Massachusetts	633	672	11.3	6.1	11.1	11.5	10	10	43	46	[3]10	[3]13
Michigan	749	815	18.0	8.8	8.4	8.9	8	8	25	[3]37	[3]39	39
Minnesota	408	440	15.4	8.0	10.7	11.2	15	16	[3]33	[3]40	[3]14	[3]16
Mississippi	221	253	17.0	14.4	10.0	10.8	30	30	27	20	22	[3]20
Missouri	558	601	11.4	7.6	11.9	12.6	11	11	42	42	6	[3]4
Montana	69	75	5.1	9.5	9.9	10.0	43	43	50	34	23	[3]29
Nebraska	183	194	11.8	6.2	12.3	12.6	34	35	41	45	[3]3	[3]4
Nevada	31	44	70.4	42.9	6.3	7.4	49	49	3	1	49	49
New Hampshire	78	87	15.8	11.4	10.6	10.6	39	40	[3]31	27	[3]19	22
New Jersey	694	767	24.4	10.6	9.7	10.5	9	9	17	28	[3]25	[3]23
New Mexico	70	90	37.7	28.2	6.9	7.9	42	39	5	6	48	47
New York	1,951	2,030	15.8	4.0	10.7	11.2	1	2	[3]31	50	[3]14	[3]16
North Carolina	412	492	32.7	19.5	8.1	9.0	14	14	7	8	41	38
North Dakota	66	73	13.3	10.3	10.7	11.5	45	44	36	29	[3]14	[3]13
Ohio	993	1,066	11.2	7.3	9.3	9.9	5	7	44	44	[3]32	[3]32
Oklahoma	299	334	20.1	11.8	11.7	12.3	24	25	22	25	8	8
Oregon	226	259	23.5	14.7	10.8	11.3	29	29	19	[3]17	13	15
Pennsylvania	1,267	1,377	12.7	8.7	10.7	11.6	3	3	37	39	[3]14	12
Rhode Island	104	113	16.1	8.9	10.9	12.2	37	37	30	[3]35	12	9
South Carolina	190	229	26.8	20.7	7.3	8.1	32	31	13	7	[3]46	46
South Dakota	80	85	12.5	5.9	12.1	12.5	38	41	[3]38	[3]47	5	7
Tennessee	382	441	24.0	15.5	9.7	10.5	16	15	31	15	[3]25	[3]23
Texas	988	1,158	32.9	17.3	8.8	9.5	6	5	6	11	37	36
Utah	77	91	29.2	18.2	7.3	7.6	40	38	10	9	[3]46	48
Vermont	47	52	8.6	9.9	10.6	11.0	46	47	47	30	[3]19	19
Virginia	364	424	26.6	16.4	7.8	8.5	18	18	14	14	44	43
Washington	320	365	15.4	13.9	9.4	10.3	22	21	[3]33	22	[3]30	28
West Virginia	194	211	12.5	8.9	11.1	11.7	31	33	[3]38	[3]35	[3]10	11
Wisconsin	471	512	17.4	8.8	10.7	11.1	13	13	26	[3]37	[3]14	18
Wyoming	30	33	16.6	9.6	9.1	8.8	50	50	28	[3]31	[3]34	40

[1] Corrected for errors in numbers of centenarians.

[2] States ranked in decreasing order; State with largest quantity is ranked 1.

[3] Tied in ranking. States with identical quantities receive identical rank numbers with following rank number or numbers skipped to allow for the number in the tie; e.g. 3 States tied for 5th place will each receive rank of 5 but next State will be ranked 8 to compensate for skipping of 6th and 7th rank. The 3 States would be shown as rank 5t.

Source of date: Bureau of the Census. Estimates and computations supplied.

RESIDENT POPULATION, TOTAL AND AGED 65 PLUS, STATES IN RANK NUMBER ORDER, 1975

Rank	Total, all ages: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	65 plus: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	Rank
1	California	21,185	9.9	9.9	California	2,056	9.2	9.2	1
2	New York	18,120	8.5	18.4	New York	2,030	9.1	18.3	2
3	Texas	12,237	5.7	24.1	Pennsylvania	1,377	6.2	24.5	3
4	Pennsylvania	11,827	5.6	29.7	Florida	1,347	6.0	30.5	4
5	Illinois	11,145	5.2	34.9	Texas	1,158	5.2	35.7	5
6	Ohio	10,759	5.1	40.0	Illinois	1,153	5.2	40.9	6
7	Michigan	9,157	4.3	44.3	Ohio	1,066	4.8	45.7	7
8	Florida	8,357	3.9	48.2	Michigan	815	3.6	49.3	8
9	New Jersey	7,316	3.4	51.6	New Jersey	767	3.4	52.7	9
10	Massachusetts	5,828	2.7	54.3	Massachusetts	672	3.0	55.7	10
11	North Carolina	5,451	2.6	56.9	Missouri	601	2.7	58.4	11
12	Indiana	5,311	2.5	59.4	Indiana	531	2.4	60.8	12
13	Virginia	4,967	2.3	61.7	Wisconsin	512	2.3	63.1	13
14	Georgia	4,926	2.3	64.0	North Carolina	492	2.2	65.3	14
15	Missouri	4,763	2.2	66.2	Tennessee	441	2.0	67.3	15
16	Wisconsin	4,607	2.2	68.4	Minnesota	440	2.0	69.3	16
17	Tennessee	4,188	2.0	70.4	Georgia	430	1.9	71.2	17
18	Maryland	4,098	1.9	72.3	Virginia	424	1.9	73.1	18
19	Minnesota	3,926	1.8	74.1	Alabama	378	1.7	74.8	19
20	Louisiana	3,791	1.8	75.9	Kentucky	368	1.6	76.4	20
21	Alabama	3,614	1.7	77.6	Washington	365	1.6	78.0	23
22	Washington	3,544	1.7	79.3	Iowa	364	1.6	79.6	21
23	Kentucky	3,396	1.6	80.9	Louisana	346	1.5	81.1	22
24	Connecticut	3,095	1.5	82.4	Maryland	340	1.5	82.6	24
25	Iowa	2,870	1.4	83.8	Oklahoma	334	1.5	84.1	25
26	South Carolina	2,818	1.3	85.1	Connecticut	321	1.4	85.5	26
27	Oklahoma	2,712	1.3	86.4	Kansas	285	1.3	86.8	27
28	Colorado	2,534	1.2	87.6	Arkansas	271	1.2	88.0	28
29	Mississippi	2,346	1.1	88.7	Oregon	259	1.2	89.2	29
30	Oregon	2,288	1.1	89.8	Mississippi	253	1.1	90.3	30
31	Kansas	2,267	1.1	90.9	South Carolina	229	1.0	91.3	31
32	Arizona	2,224	1.0	91.9	Arizona	223	1.0	92.3	32
33	Arkansas	2,116	1.0	92.9	West Virginia	211	.9	93.2	33
34	West Virginia	1,803	.8	93.7	Colorado	210	.9	94.1	34
35	Nebraska	1,546	.7	94.4	Nebraska	194	.9	95.0	35
36	Utah	1,206	.6	95.0	Maine	125	.6	95.6	36
37	New Mexico	1,147	.5	95.5	Rhode Island	113	.5	96.1	37
38	Maine	1,059	.5	96.0	Utah	91	.4	96.5	38
39	Rhode Island	927	.4	96.4	New Mexico	90	.4	96.9	39
40	Hawaii	865	.4	96.8	New Hampshire	87	.4	97.3	40
41	Idaho	820	.4	97.2	South Dakota	85	.4	97.7	41
42	New Hampshire	818	.4	97.6	Idaho	79	.3	98.0	42
43	Montana	748	.3	97.9	Montana	75	.3	98.3	43
44	District of Columbia	716	.3	98.2	North Dakota	72	.3	98.6	44
45	South Dakota	683	.3	98.5	District of Columbia	71	.3	98.9	45
46	North Dakota	635	.3	98.8	Hawaii	57	.2	99.1	46
47	Nevada	592	.3	99.1	Vermont	52	.2	99.3	47
48	Delaware	579	.3	99.4	Delaware	50	.2	99.5	48
49	Vermont	471	.2	99.6	Nevada	44	.2	99.7	49
50	Wyoming	374	.2	99.8	Wyoming	33	.2	99.9	50
51	Alaska	352	.2	100.0	Alaska	9	.1	100.0	51

Source of data: Bureau of the Census. Computations supplied.

95TH CONGRESS
1st Session

SENATE

REPORT
No. 95–88

PART 1

DEVELOPMENTS IN AGING: 1976

APRAIL 7 (legislative day, FEBRUARY 21), 1977.—Ordered to be printed

Mr. CHURCH, from the Special Committee on Aging, submitted the following

REPORT

together with

MINORITY VIEWS

[Pursuant to S. Res. 373, 94th Cong.]

CHAPTER I

WHAT NEXT STEPS ON INCOME?

What may appear to be two contradictory statements appear in this chapter.

It is reported that since 1970 social security beneficiaries in the United States have received six across-the-board increases totaling 93.5 percent.

But it is also reported that poverty among older Americans is again on the increase in the United States and that—if new poverty standards become official—that the number of poor elderly persons would perhaps double.

Further examination reveals that inflation and unemployment are not the only forces which have resulted in this situation.

There is a fundamental question about adequacy of social security and supplemental security income benefits in the face of rising living costs.[1]

That question deserves an answer, even at the same time that other questions related to social security must be dealt with, including: Short-term and long-range financing problems; the trend toward discontinuance of social security among municipal employees; and the need to establish an independent Social Security Administration.

I. HOW FAR SHORT OF ADEQUACY IS SOCIAL SECURITY NOW?

Nearly 33 million social security beneficiaries received a 6.4 percent cost-of-living increase in July. Furthermore nearly 4.3 million supplemental security income recipients received a comparable percentage increase in their Federal payments, since the SSI automatic escalator provision is pegged to the social security cost-of-living adjustment mechanism. In addition, the social security cost-of-living adjustment was passed through to most railroad retirement beneficiaries as an increase in their tier No. 1 benefits (the portion calculated on the basis of their combined social security-railroad retirement earnings).

With the 6.4 percent increase, average social security monthly benefits rose to:

—$217 ($2,604 a year) for a retired worker alone;
—$370 ($4,440 a year) for a retired worker and wife (both receiving benefits);
—$479 ($5,748 a year) for a disabled worker with a wife and one or more children;
—$208 ($2,496 a year) for an aged widow; and
—$243 ($2,916 a year) for disabled workers.

The maximum benefit for a retired worker aged 65 in 1976 now amounts to $387.30 a month ($4,647.60 a year). For a retired couple similarly situated, the maximum monthly benefit is $581 a month ($6,972 a year). The minimum monthly benefit for a worker retiring at age 65 is $107.90 ($161.90 for a couple similarly situated).

Since 1970, social security beneficiaries have received six across-the-board increases totaling 93.5 percent.[2] These adjustments have

[1] For a detailed description of the daily personal struggle with rising prices, see chapter II, "Coping With the Cost of Living," from *Developments in Aging: 1975 and January–May 1976*, a report of the U.S. Senate Special Committee on Aging, June 1976.

[2] Since 1970 social security benefits have increased as follows:

Date of enactment	Effective date	Percentage across-the-board increases
Dec. 30, 1969	January 1970	15.0
Mar. 17, 1971	January 1971	10.0
July 1, 1972	September 1972	20.0
Dec. 31, 1973	June 1974	*11.0
Cost-of-living adjustment	June 1975	8.0
Do	June 1976	6.4

*This 11-percent increase was payable in 2 steps: 7 percent effective for March, April, and May 1974, with the full 11 percent effective for months after May.

NOTE.—Individually, the increases equal 70.4 percent for the 6-year period. However, because of the compound effect of adding one increase on top of another, the aggregate total is 93.5 percent.

helped considerably to improve the economic well-being of older Americans.

But when compared with other standards—such as the Bureau of Labor Statistics Intermediate Budgets for Retired Couples—social security benefits fall short of adequacy for many older Americans.

Most elderly persons, to be sure, receive other types of income besides social security. However, social security is the economic mainstay for the vast majority of older Americans. It accounts for over half the income for 7 out of 10 individual beneficiaries and 1 out of 2 elderly couple beneficiaries.

New Retired Couples Budget

In August 1976, the Department of Labor announced the updated retired couples budgets for urban families, based on autumn 1975 consumption patterns. The three hypothetical budgets—lower, intermediate, and higher—increased from 6.5 to 7 percent from 1974 to 1975. The intermediate budget for a retired couple totaled $6,465, or nearly $539 a month. Average monthly social security benefits for a retired couple in 1976 amounted to $370, or only 69 percent of the 1975 BLS modest standard of living for a retired couple. Even the lower budget ($4,501 a year or $375 a month) exceeded the average social security monthly benefit for a retired couple in 1976.

An estimated 3.1 million aged families—or almost 38 percent of all elderly families—have annual incomes below the BLS intermediate budget. And 1.5 million elderly families (or 19 percent) live on less than the BLS lower budget for a retired couple in a urban area.

THREE BUDGETS FOR A RETIRED COUPLE, URBAN UNITED STATES—AUTUMN 1975

(Issued in August 1976)

	Lower	Intermediate	Higher
Total	$4,501	[1] $6,465	[1] $9,598
Food	1,427	1,912	2,398
Housing	1,514	2,192	3,430
Transportation	297	577	1,059
Clothing	198	334	514
Personal care	128	188	275
Medical care	552	555	559
Other family consumption	191	317	628
Other items	194	389	736

[1] Subcategory figures vary by $1 from the total intermediate and higher budgets because of rounding.

Source: Department of Labor.

Average monthly social security benefits also fall below the 1975 poverty lines in certain cases. For example, the average benefit for an aged widow now amounts to $2,496, or $78 below the $2,574 poverty threshold for an elderly single woman living in a nonfarm area. Average monthly benefits ($2,604 a year) for retired workers are slightly above the 1975 poverty index ($2,581 a year) for single-aged persons living in nonfarm areas.

II. THE MEANING OF THE NEW POVERTY FIGURES

The 1976 poverty report [3] by the Bureau of the Census revealed that nearly 232,000 older Americans were added to the poverty rolls in 1975, reversing a longstanding downward trend. Nearly one out of every seven persons 65 or older lived in poverty, under the official Government definition. All in all, 3.3 million older Americans were classified as poor in a Nation with a gross national product averaging $1.7 trillion for 1976.

POVERTY THRESHOLDS IN 1975 FOR PERSONS 65 OR OLDER

	Weighted average	Nonfarm	Farm
Individual	$2,572		
Both sexes		$2,581	$2,196
Male		2,608	2,216
Female		2,574	2,187
Two-person family with head aged 65 or older	3,232		
Both sexes		3,257	2,772
Male		3,260	2,772
Female		3,237	2,770

Source: Bureau of the Census.

But these figures—as depressing as they may be—do not reflect the true dimensions of the retirement income crisis now affecting many elderly persons. The poverty standards, for instance, reflect barebone existence. On a weighted basis the poverty index is $2,572 for an aged single person, or less than $50 a week to pay for housing, food, medical care, transportation, clothing, utilities, and other everyday necessities. For a 2-person family with an aged head, the poverty line is $3,232, or about $62 a week.

Moreover, the poverty figures include only the noninstitutionalized elderly. Approximately 1 million aged persons live in institutions. Of this total, an estimated 500,000 are projected to be poor. However, the institutionalized elderly are not included in the Bureau of the Census tabulations.

Census poverty figures also do not include persons living with others—usually relatives—who have sufficient incomes to raise them out of poverty, even though their individual income is below the poverty line. Over 1 million older Americans are not classified as poor because of these circumstances.

The harsh reality is that perhaps 5 million older Americans would now live in poverty if the "hidden poor" were counted. And this is under a definition that many authorities regard as inadequate for subsistence.

[3] "Current Population Reports, Consumer Income, Money Income and Poverty Status of Families and Persons in the United States: 1975 and 1974 Revisions (advance report)," Series P-60, No. 103, September 1976, U.S. Department of Commerce, Bureau of the Census, p. 3. The number of persons 65 or older living in poverty in 1974 is approximately 200,000 lower than reported in the committee's annual report, *Developments in Aging: 1975 and January-May 1976*, because the Bureau of the Census revised the method of processing certain nonrespondents to the income questionnaire. The effect was to change the originally reported poverty figure of 3,308,000 for persons 65 or older to 3,085,000. In the revised report, the Bureau of the Census was able to assign dollar amounts to some respondents who indicated that they received particular types of other income but did not know the exact amount received.

A. The Near Poor

In addition, nearly 2.2 million older Americans are considered marginally poor. A person can be regarded as "near poor" if his or her income is between 100 and 125 percent of the poverty thresholds.

Weighted near-poor thresholds for persons 65 or older in 1975

Individual	$3,215
Two-person family with an aged head	4,040

Source: Bureau of the Census.

If the near poor are added to the official poverty figures and the hidden poor estimates, more than 7 million older Americans would have incomes either below the poverty line or so very close to it that they would have a difficult time appreciating the difference.

B. Shortcomings of Present Procedures for Determining Poverty

The concept of poverty is built around the Department of Agriculture's economy food plan of 1961 and the national average ratio of family food expenditures to total family after-tax income as measured in the 1955 Department of Agriculture household food consumption survey. Overall, it includes 124 separate indexes differentiating families by size, number of children, the age and sex of the head, and farm or nonfarm residence. Each year these indexes are updated to reflect changes in the Consumer Price Index.

The 1974 Elementary and Secondary Education Act Amendments[4] directed the Department of Health, Education, and Welfare to consider alternatives to improve the accuracy and currency of the present measure of poverty for purposes of allocating funds authorized by title I of the act. The resulting HEW report—*The Measure of Poverty*[5]—has crucial implications for the elderly.

One of the alternatives considered by the poverty studies task force would involve two changes in the poverty level. First, a more recent food plan of the Department of Agriculture would be used to reflect revised nutritional requirements and more recent family food choices. The second adjustment changes the multiplier to conform to the 1965 Department of Agriculture survey rather than the 1955 survey which employed a 3 to 1 income to food ratio. A slightly higher ratio is used, however, for one- and two-person families, since their total consumption requirements and fixed costs are different from those of larger families. Under the second adjustment, for instance, the multiple would be changed from 3.7 to 1 to 4.3 to 1 for two-person families. These two changes have a major impact on the poverty thresholds for one- and two-person families, and particularly elderly families.

A report to Congress in February 1977 presents new findings for 1975 concerning the number of persons living in poverty by States based on the present measure and several alternatives. The two changes

[4] Public Law 93-380, approved Aug. 21, 1974.
[5] *The Measure of Poverty*, U.S. Department of Health, Education, and Welfare, April 1976.

in the alternative method would raise the poverty lines by 38 to 39 percent for aged single persons and elderly couples. *Under these definitions, the number of older Americans living in poverty would nearly double.* The possible changes are reflected in the table below:

1975 POVERTY THRESHOLDS FOR PERSONS 65 OR OLDER

	Nonfarm index for an aged person	An alternative measure of poverty for an aged couple
Individual	$2,581	$3,610
2-person family with head aged 65 or older	3,257	4,512

C. Congressional Budget Office Report

In January 1977, the Congressional Budget Office completed and released a study* (originally requested by Senator Mondale) designed to estimate the impact of public welfare programs on the population and especially the poor. Using very sophisticated techniques and extensive modeling, the CBO study first estimated the number of older families (heads aged 65 plus, including one-person families) who would fall below an estimated official poverty threshold for the fiscal year ending June 30, 1976. They departed from the Census Bureau procedures by taking into account the institutionalized, the residents of the territories, and correction for nonresponse and under-reporting of income in the Census Bureau's current population surveys.

Then, using only gross (pretax) income without any cash benefits like social security, SSI, etc., they estimated that 9,297,000 older families, or 57.7 percent of all older families, would be designated as poor. Adding in social insurance type benefits reduces the estimate to 2,977,000 or 18.5 percent of older families. Adding in other cash benefits (having needs test rather than social insurance, like SSI) reduces the number of poor older families to 2,107,000, or 13.1 percent. Adding the "value" of in-kind or third-party payment systems like food stamps, medicare, medicaid, and rent supplements further reduces the number of poor older families to 646,000, or 4.0 percent. Finally, adjusting the previous figure for net income after taxes, the estimated number of older families in poverty rises to 654,000, or 4.1 percent.

It is important to note that although this interesting study starts with the same definition of the proverty threshold, everything else is based on large numbers of assumptions and constructed models. Information on the specific families who actually received the cash and in-kind benefits and on the families who may have received multiple benefits on the actual medicare payments and their value on behalf of a single family, and so on, was not available and was calculated as estimates. Essentially, the point of view depends on the definition of "income" and standard of living.

III. WHAT DOES SSI BUY TODAY?

Since January 4, 1974, the low-income blind, disabled, and aged receive a federally administered public assistance payment—supple-

*"Poverty Status of Families Under Alternative Definitions of Income." Background Paper No. 17. Congressional Budget Office, Jan. 13, 1977.

mental security income—which now provides for a monthly Federal payment level of $167.80 for an individual and $251.80 for a couple. SSI was enacted as part of the 1972 Social Security Amendments (Public Law 92–603) and replaced the former adult categorical assistance programs to the blind, disabled, and aged which were administered by the States.

Approximately 4.3 million persons received SSI payments during 1976: about 2.24 million aged, 1.98 disabled, and 0.076 million blind. Of the 2.24 million aged recipients, nearly 88.5 percent lived in their own households, 7.3 percent lived in another's household, and 4.1 percent lived in institutions supported by medicaid. Of the aged recipients, 29.4 percent were male and 70.5 percent were female. The white elderly accounted for 64.9 percent of the SSI recipients, while blacks constituted 24.1 percent and "others" accounted for 2.6 percent. Nearly 69.9 percent of the aged recipients received social security benefits at an average monthly benefit of $137.67. Unearned income was received by 11.3 percent of the aged recipients at a monthly average of $56.71.[6]

An individual living in his or her own residence receives $167.80. If an individual resides in the home of another, his or her benefit is reduced by one-third—to $111.87. If the SSI recipient lives in a facility—public or private—which receives medicaid benefits on his or her behalf, he or she is eligible for a maximum of $25 per month. However, SSI recipients who reside in other public institutions are ineligible for SSI benefits. If the public institution has fewer than 16 individuals, it will not be considered a public institution and therefore the residents would be potential recipients for SSI—this change was enacted in 1976 and is described in section IV of this chapter.

In addition to the SSI Federal payment which supplements one's low income to the $167.80 level, the States also have the option of supplementing their blind, disabled, and elderly SSI recipients' payments. Currently, 39 States supplement aged recipients and the other 11 do not.[7] The States spent approximately $1.3 billion for supplemental payments in comparison to the $5.3 billion supported by the Federal level.[8]

A. Adequacy of SSI

Under the revised measure of poverty of an aged male, the 1975 threshold would be approximately $300.83 per month. The same individual, if eligible for SSI, would receive a maximum Federal payment of only $167.80 per month—$133.03 below the poverty threshold for an aged male in 1975. In addition, only in Alaska and California in certain categorized living situations would the same individual receive enough State supplementation to place him or her above the $300.83 poverty threshold.[9] *Therefore, in virtually every State of the country an aged individual receiving both Federal and State SSI payments,*

[6] Social Security Administration estimates based on June 1976 statistics.

[7] The 39 States that supplement do not supplement all residential categories of aged SSI recipients. For example, out of the 39 States, only 22 supplement individuals living independently.

[8] Based on Social Security Administration's estimates for fiscal year 1976.

[9] In Alaska, if an aged individual lives independently in a shelter which costs $35 or more per month, he or she receives a State supplementation of $166 per month. In California, if an aged individual lives independently in a resident without cooking facilities, he or she is eligible for $140 in State supplementation.

when available, would receive total benefits below the poverty threshold for 1975. The gap between the SSI Federal payment level and poverty thresold for 1975 increased considerably with the new figures released in December 1976. Prior to this time, the 1975 weighted poverty threshold for an aged individual had been $214.33 per month—a $46.53 difference. Therefore, the inadequacy of SSI to provide a significant means of supporting the needy blind, disabled, and aged of this country is becoming more apparent.

Examples of this inadequacy are found throughout the Nation. In New York City, a survey of the SSI recipients of the city shows that 25 percent of those interviewed stated that SSI provides insufficient income.[10] And New York City is located in a State which supplies a $61 monthly State supplement to aged individuals living independently—one of the highest State supplements in the country.

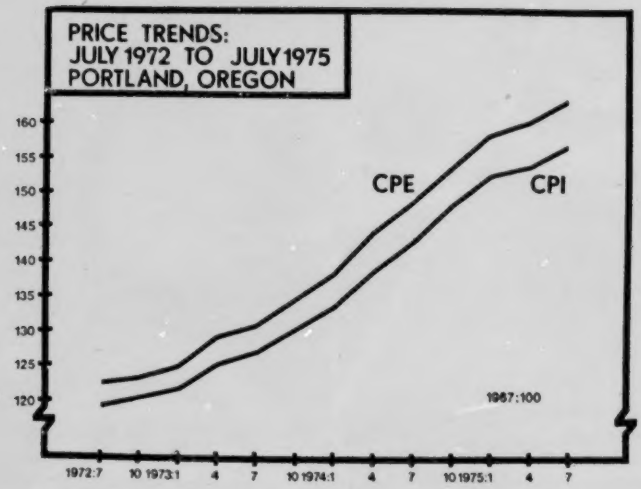
The same survey shows that one-third to one-half say they are "worse off since the implementation of SSI for several reasons: inflation, including rent increases; loss of food stamps [New York, until 1977, opted to cash out the food stamp benefit as a portion of the State supplementation]; and other loss of income sources." The researchers speculate that the combination of a flat grant system (SSI) with a rising inflation, may have helped to "create a new class of elderly poor."

Similar findings were also reported in other regions. In Oregon, research supported by the Social Security Administration indicates that the elderly SSI recipient is also struggling to maintain an adequate standard of living. An aged individual living independently in Oregon receives only $12 in State supplementation. Researchers found that aged SSI recipients, like most elderly, spend as much as 85 to 90 percent of their monthly income for housing, food and medical care. This leaves very little for any other necessities or personal expenditures.

The study, conducted by the Institute of Gerontology at Portland State University, has concentrated upon the movements of the Consumer Price Index (CPI) for the Portland area and the movement of the Consumer Price Index for the Elderly (CPE). In testimony before the U.S. Senate Committee on Aging, one of the researchers described early findings of the study:

> From an initial examination of the trends of these two indexes, we see that the CPE has been above the CPI consistently over the past 3-year period. In July of this year when the general CPI for Portland was 157.1–167 equals 1.00, the consumer price index for our sample (SSI recipients) stood at 163, indicating an almost 6-percent spread between the two indexes of the cost of living.

[10] Progress report on joint CSS/DSS study of impact of supplemental security income program on New York City's elderly recipients, Department of Social Services of New York City and Community Service Society of New York, August 1976.



These lines, however, do not tell us if, in fact, the inflation we have experienced over the past 3 years has been more harmful to the low-income elderly than the general public. To answer this question we have compared the rates of change in the two price indexes for the period through a statistical analysis. We found that it is readily apparent from the chart we later constructed that the two indexes are diverging. *That is, the difference between the general CPI and the CPE has become greater in each of the past 3 years.* [Emphasis added.]

In summing up the impact of this situation, the witness stated:

> When we consider that not only do the elderly have less purchasing power than the general public, but that they are losing their purchasing power at a faster rate, we must be struck with a sense of the need for immediate action.[11]

B. Steps To Improve SSI

As described in section IV of this chapter, several legislative actions were taken during the 94th Congress to improve the SSI program. In addition, Senator Frank Church, chairman of this committee, introduced a bill (S. 1992), the Social Security Cost-of-Living Improvement Act, which would develop a special consumer price index for the elderly—one which would more accurately reflect the overall impact of rising prices upon the aged. Senator Church gave this rationale for the special index:

> In recent years some of the sharpest increases have occurred in those areas where the aged's greatest expenditures are concentrated. A special index could give appropriate weight to these increases in terms of the impact upon older Americans.[12]

[11] Testimony by John Dobra of Portland State University before the U.S. Senate Committee on Aging, "Future Directions in Social Security: Impact of High Cost of Living," Portland, Oreg., Nov. 25, 1975.

[12] Statement of Senator Frank Church, upon introduction of S. 1992, on June 23, 1975.

In addition, S. 1992 would provide for a semiannual cost-of-living adjustment instead of the current annual adjustment. This twice-a-year adjustment would occur when accelerated inflation (over 6 percent) occurs within the 12-month period.

IV. NEXT STEPS TOWARD SOCIAL SECURITY AND SSI ADEQUACY

Nearly 9 out of 10 persons 65 or older now receive or are eligible to receive social security benefits. And about 1 out of every 10 persons 65 or older receive SSI payments, although the number of eligible older Americans is considerably larger. Quite clearly, any comprehensive income strategy for older Americans must include social security and SSI.

A. Social Security

Social security beneficiaries received a cost-of-living adjustment in July, based on the increase in the Consumer Price Index (the Government's yardstick for measuring inflation) from the first quarter (January, February, and March) in 1975 to the first quarter in 1976. The CPI includes all items affecting older and younger Americans, including transportation, housing, and other expenses.

However, in recent years some of the sharpest increases have occurred in areas where the elderly have their greatest expenditures: Housing, food, transportation, and medical care. These items typically account for about $4 out of every $5 in an aged family's budget. In fact, the Bureau of Labor Statistics allocated 78 to 84 percent of the three budgets for retired couples to housing, food, transportation, and medical care (see table below).

PERCENTAGE INCREASES IN CONSUMER PRICE INDEX ITEMS AT SELECTED INTERVALS DURING THE PAST 4 YEARS

	Sept. 1975 to Sept. 1976	Sept. 1974 to Sept. 1976	Sept. 1973 to Sept. 1976	Sept. 1972 to Sept. 1976
Consumer price index (all items)	5.5	13.8	27.4	37.6
Food	2.1	10.1	22.5	45.6
Fuel oil, No. 2	5.6	12.4	86.9	112.2
Housing	6.3	15.9	31.4	37.9
Medical care	9.1	21.1	35.9	41.2
Hospital daily service charges	12.0	27.5	42.7	47.5
Transportation	9.1	19.2	36.8	40.1

During the past 4 years (from September 1972 to September 1976), the overall CPI increased by 37.6 percent. But the four items with the greatest impact on the elderly—housing, food, medical care, and transportation—all rose at a faster rate. Food, for example, leaped forward at a 45.6-percent level. On the other fronts, medical care prices increased by 41.2 percent, transportation by 40.1 percent, and housing by 37.9 percent.

Senator Church introduced legislation (S. 1992) during the 94th Congress to strengthen the automatic escalator provision in two key respects.

First, S. 1992 would direct the Secretary of Labor and the Secretary of Health, Education, and Welfare to develop a special consumer price index. The purpose is to reflect more accurately the overall impact of

rising prices upon the aged. Senator Church gave this rationale for the special index:

> . . . A special index is needed, it seems to me, because the inflationary rate for specific items in the overall Consumer Price Index can vary markedly. In recent years some of the sharpest increases have occurred in those areas where the aged's greatest expenditures are concentrated. A special index could give appropriate weight to these increases in terms of the impact upon older Americans.[13]

Second, the Social Security Cost-of-Living Improvement Act would authorize two adjustments a year (in April and October), provided the Consumer Price Index increased by at least 3 percent from one base period to another. Social security beneficiaries now receive only one cost-of-living adjustment—in July—whether the inflationary rate is 3 percent or 13 percent. More timely adjustments are now available for civil service annuitants under legislation [14] approved by Congress in 1976 to provide semiannual cost-of-living adjustments.

During the 1976 campaign, candidate Jimmy Carter endorsed the concept of more timely social security increases when he said:

> The cost-of-living adjustment mechanism should be made more responsive during periods of rapid inflation so that beneficiaries do not have to wait a full year for catch-up increases." [15]

Mr. Carter also called for other substantive actions to improve social security, including:

—Eliminating sex discrimination under the program;
—Improving the treatment of the disabled, such as reducing the waiting period before disability benefits can begin; and
—Liberalizing the earnings limitation for social security beneficiaries under age 72.

B. Supplemental Security Income

As described in section III, the Federal level of supplemental security income (SSI)—$2,013.60 ($167.80 per month) for an individual and $3,021.60 ($251.80 per month) for a couple—was significantly below the weighted poverty threshold of 1975 for persons 65 or older—$2,572 ($214.33 per month) for individuals and $3,232 ($269.33 per month) for two-person family. Even more dramatic were the differences between the Federal SSI payment level and the revised measure of poverty for 1975. For an aged male, the new statistics show $3,610 ($300.83 per month), $1,596.40 above the Federal SSI level for an individual.

Like social security beneficiaries, supplemental security income recipients received a 6.4 percent cost-of-living increase in July 1976.

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[13] *Congressional Record*, June 23, 1975, p. S 11298.

[14] Public Law 94-440 (approved Oct. 1, 1976) provides a new method of computing civil service annuity adjustments semiannually on the basis of the actual cost-of-living increase. This computation will be made each January and July. Annuity checks reflecting the cost-of-living adjustments will be mailed no later than April (for the January computation) and October (for the July computation). Public Law 94-440 also eliminates the 1-percent add-on to Federal pension cost-of-living adjustments.

[15] "Carter-Mondale Presidential Campaign for America's Third Century, Why Not Our Best?", Sept. 22, 1976, p. 4.

Based on the increase in the Consumer Price Index (CPI), the SSI Federal payment level rose accordingly by 6.4 percent to elevate the levels of payment for SSI as shown below.

SSI FEDERAL PAYMENTS

	July 1975	July 1976
Individual	$157.70	$167.80
Couple	236.60	251.80
Essential person [1]	79.00	84.00

[1] According to Federal regulations (Federal Register, vol. 39, No. 184, Sept. 20, 1974), an essential person is any person who for the month of December 1973 was a person whose needs were taken into account in determining the need of a qualified individual for aid or assistance under a State plan approved under titles I, X, XIV, or XVI of the Social Security Act, as in effect for June 1973, and who: (a) lives in the homes of the qualified individual; and (2) is not eligible in his or her own right for supplemental security income benefits; and (c) is not an eligible spouse of the qualified individual or any other individual; and does not have income or resources in an amount that will cause the qualified individual to lose eligibility for benefits.

Several other steps were taken in 1976 to improve SSI for the 4.3 million blind, disabled, and aged recipients. Among the major changes:

—The Humphrey amendment which requires States that supplement SSI benefits to pass along the Federal cost-of-living increase. The purpose is to assure that a qualifying individual's total income will increase by the amount of the Federal SSI increase. However, States are allowed, as an alternative, to make changes (including reductions) in their State supplementary benefits, provided that they do not reduce their overall level of funding for the program. This provision becomes effective in July 1977 (Public Law 94–585, enacted Oct. 21, 1976);

—An amendment sponsored by Senator Clark and Congressman Ketchum which exempts the value of one's home for the purpose of determining SSI eligibility. The home, therefore, will not be counted as a resource under the $1,500 limitation for an individual ($2,250 for a couple) (Public Law 94–569, enacted Oct. 20, 1976);

—An amendment to the unemployment compensation amendments which preserves medicaid eligibility for individuals who cease to be eligible for SSI benefits because of cost-of-living increases in social security benefits (Public Law 94–566, enacted Oct. 20, 1976);

—An amendment to the unemployment compensation amendments provides for the treatment of eligible SSI couples as individuals when one spouse is institutionalized and a reduction in benefits would be required (Public Law 94–566, enacted Oct. 20, 1976);

—An amendment to the unemployment compensation amendments which provides that State assistance to an individual or on his or her behalf to a private nonmedical group home would not be counted as unearned income in determining SSI benefits. This measure also permits SSI benefits to be paid to eligible persons living in public institutions serving no more than 16 persons (Public Law 94–566, enacted Oct. 20, 1976);

—An amendment sponsored by Senator Hathaway to provide a 3-month presumptive eligibility period for SSI benefits for the blind. This is similar to the treatment for the disabled. Under prior law, the presumptive eligibility period for the blind was 1 month (Public Law 94–569, enacted Oct. 20, 1976);

—The Church amendment to provide that SSI recipients who leave their own households and live in the household of another because of a Presidentially declared disaster will not have their benefits reduced by one-third. It also excludes as countable income any assistance received under the Disaster Relief Act of 1974 or any other assistance received under a Presidentially declared disaster. (Public Law 94–331, enacted June 30, 1976, and Public Law 94–455, enacted Oct. 4, 1976, extended the grace period for this amendment to 18 months);

—An amendment which provides for the exclusion of HUD section 8 housing subsidy payments as countable income or resources for the purposes of determining eligibility for SSI (Public Law 94–375, enacted Aug. 3, 1976);

—An amendment which extended until June 30, 1977, the allowance for all SSI recipients to receive food stamps—except the cash-out States: Massachusetts and California (Public Law 94–365, enacted June 30, 1976);

—An amendment which makes permanent the authority for reimbursement of States for interim assistance payments to SSI applicants awaiting the final determination of their eligibility for SSI (Public Law 94–365, enacted June 30, 1976);

—An amendment which permits the Social Security Administration to use existing SSI hearing examiners to hear social security and medicare cases until December 31, 1978, and provides SSI claimants with the same rights to hearings and to administrative and judicial review as available to social security and medicare claimants. This measure also increases to 60 days the time in which a person can request a hearing after a claim has been disallowed (Public Law 94–202, enacted Jan. 2, 1976); and

—An amendment which authorizes California not to implement that food stamp program for SSI recipients but to provide instead for a higher level of State supplementary benefits.

Despite these improvements, SSI still fails to provide adequate economic stability to many of the 4.3 million recipients.

OUTREACH SHORTCOMINGS

Many people now potentially eligible for SSI are still not receiving benefits. According to the Social Security Administration, the program is now reaching about 4.3 million persons—approximately 2.24 million aged, 1.98 million disabled, and 0.076 million blind. However, when compared to the figures stated earlier in this chapter, that nearly 7 million aged alone are poor or near poor, there is clear-cut evidence that SSI is not reaching a vast number of potential recipients.

In response to a request from Congressman Donald Fraser, the General Accounting Office (GAO) undertook a study of the "Efforts Made to Locate and Enroll Potential Recipients of the Supplemental Security Income Program for the Aged, Blind, and Disabled." This December 1976 report concluded:

> Because outreach efforts to market the supplemental security income program did enroll some new recipients, continued outreach efforts may be desirable. The limited results achieved in all past and present outreach projects

indicate, however, that Social Security's past estimates of the supplemental security income universe population appear unrealistic.

Social Security should continue its supplemental security advertisement program through media and encourage and actively support supplemental security income outreach efforts by State and local agencies and other special interest groups and organizations. On a national scale, additional massive outreach efforts geared to achieving considerable increases in the supplemental security income caseloads would not be warranted.

Phase II of the SSI-Alert [16] is still in operation at various levels in different States. However, this stage depends on the State and area agencies on aging to combine any outreach efforts with their required information and referral programs. There are still inadequacies, as evidenced by the small numbers of new eligibles coming onto the program. Quite clearly, cooperative efforts between aging service programs and the Social Security Administration are needed to develop a far-reaching and effective method of educating the needy about the availability of SSI.

In addition, the Social Security Administration should make an effort to educate SSI recipients about the availability of other forms of assistance, for example, medicaid, food stamps, and social services. SSI recipients are automatically eligible for many of these services, but many are not receiving these benefits. For example, a recent report of the Social and Rehabilitation Service of HEW shows that only about 10 percent of all SSI beneficiaries receive services under title XX.[17] Efforts to educate the needy can be established by placing a qualified person from the State's public assistance office in the social security district offices to inform newly enrolled recipients about their eligibility for other benefits. Senator Frank Church included such a provision in his legislation (S. 2175) to amend the food stamp program. This measure was incorporated into the Senate Food Stamp Reform Act of 1976 (S. 3136) and would have allowed SSI recipients to apply for food stamps at local or district social security offices where qualified State public assistance personnel would be housed for the purpose of assisting the applicants in becoming eligible for food stamps, such as filling out application forms.[18]

V. NEXT STEPS TOWARD SOCIAL SECURITY SOUNDNESS IN FINANCING

The social security cash benefits trust funds (old-age and survivors insurance and disability insurance) had a $3.2 billion deficit for cal-

[16] SSI-Alert was a joint effort by the Social Security Administration, Administration on Aging, Red Cross, and other volunteer organizations, to seek out potential SSI recipients.

[17] "Social Services, U.S.A.," statistical tables, summaries and analyses of services under the Social Security Act, titles XX, IV–B, and IV–C for the 50 States and the District of Columbia, October–December 1975, Social and Rehabilitation Service, Department of Health, Education, and Welfare.

[18] The Senate passed its food stamp bill (S. 3136) on Apr. 8, 1976; however the House of Representatives failed to act upon this legislation before its adjournment and therefore the legislation is considered dead.

endar year 1976. However, the trust funds had an estimated $41.1 billion balance at the end of 1976.

Two factors have contributed to the short-term deficit now confronting social security. First, our extraordinarily high unemployment rate during the past few years has resulted in less income for the program because payroll tax contributions have been reduced. At the same time, outgo has been higher than initially projected because rising prices have triggered larger cost-of-living adjustments. Social Security Commissioner James Cardwell described the causes for the short-term deficit this way:

> It is a combination of a rise in unemployment during the last several years and the rise in the cost of living occasioning the triggering of the CPI in the system that has produced the short fall.[19]

Commissioner Cardwell also pointed out that there would have been no short-term actuarial deficit if the unemployment rate had been 5 percent—instead of the 7- to 8-percent range during the past 2 years—and the inflationary rate had been more moderate.

In addition, the Board of Trustees [20] for Social Security estimated that the long-range actuarial deficit was 7.96 for the cash benefits program. The average tax rate over the 75-year estimate period is 10.97 for employers and employees. (For more detailed discussion about the long-range actuarial deficit, see "Developments in Aging: 1975 and January–May 1976," pp. 67–69.

A. Carter Versus Ford Proposals

In his message on older Americans, President Ford called for a 0.3-percent increase in the social security payroll tax (from 5.85 to 6.15 percent) for employers and employees each, effective in 1977. Additionally, he proposed a 0.9-percent boost for self-employed persons, from 7.9 to 8.8 percent. Senator Church expressed serious misgivings about this approach, saying:

> . . . This appears to be the most regressive approach to provide additional revenue for the social security trust funds. And, it would fall heavily upon low-income wage earners. In addition, an increase in the contribution rate may intensify our already high unemployment. It may, for example, discourage employers from hiring new workers because their total payroll costs would be boosted.[21]

Others felt that a payroll tax hike in 1977 could impede the recovery from the recession. Opponents of a rate increase also pointed out that social security cash benefit trust funds will exceed $40 billion in 1976. Consequently, they asserted there was no imminent need to enact a payroll tax rate rise to become effective in 1977.

During the campaign, Governor Carter proposed to meet the short-term deficit by raising the wage base and reducing unemployment substantially. He argued against President Ford's plan, claiming it

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[19] "President's Social Security Proposals," hearings before the subcommittee on Social Security of the House Ways and Means Committee, 94th Cong., 2d sess., Feb. 2, 1976, p. 13.

[20] The Board of Trustees are the Secretary of Health, Education, and Welfare, the Secretary of Labor, and the Secretary of the Treasury.

[21] *Congressional Record*, Feb. 25, 1976, p. S 2294.

"would put an even greater burden on the average wage earner without insuring comparably greater benefits." [22]

His support for a wage base hike was based on this rationale:

> Raising the wage base, on the other hand, in addition to adding to the resources of the system, would make the tax fall more nearly equally on all income classes and would also benefit higher income earners by raising the amount of money they could receive in retirement.[23]

B. Ways and Means Committee and the Hsiao Panel Recommendations

In March the Social Security Subcommittee of the House Ways and Means Committee considered the Ford administration's plan and other alternatives to meet the short-term deficit for social security. All of these recommendations—with the exception of a proposal to raise the wage base to $17,700 in 1977 (the wage base was projected to rise to $16,500 in 1977 under provisions of existing law)—were rejected by the subcommittee. The full committee, however, voted down the subcommittee proposal to boost the wage base to $17,700 in 1977. The Social Security Subcommittee considered and rejected the following proposals:

—Raise the wage base to $18,900 in 1977 and finance a portion of the minimum benefit from general revenues.
—Increase the wage base to $18,900 in 1977.
—Finance a portion of the minimum benefit from general revenues.
—Raise the wage base to $18,300 in 1977 and provide a 0.1 percent payroll hike, from 5.85 percent to 5.95 percent in 1977.
—Authorize appropriations to the trust funds as may be required to finance benefits under social security.
—Increase the wage base to $17,500 and the contribution rate by 0.15 percent (from 5.85 percent to 6 percent) effective in 1977.
—Raise the wage base to $17,700 and the payroll tax by 0.1 percent.

In August the Consultant Panel on Social Security to the Congressional Research Service submitted its report [24] to the Senate Finance Committee and the House Ways and Means Committee. The panel, which was chaired by William Hsiao, made several recommendations relating to the short-term financing of social security:

(1) Social security should continue to be financed by payroll taxes, and not from general revenues.

(2) The maximum wage base should be moderately increased and then maintained at a point to cover the entire earnings of approximately 90 percent of all covered workers. This would mean an estimated wage base of $18,900 in 1977, instead of $16,500 as under present law.

(3) The payroll tax rate for employers and employees should be increased by 0.2 percent for each.

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[22] Page 2 of statement cited in footnote 15.
[23] Pages 2 and 3 of statement cited in footnote 15.
[24] "Report of the Consultant Panel on Social Security to the Congressional Research Service," prepared for the use of the Senate Finance Committee and the House Ways and Means Committee, 94th Cong., 2d sess., August 1976.

(4) The tax rate for self-employed persons for both old-age, survivors, and disability insurance and hospital insurance should be inincreased to 75 percent of the combined rate for employers and employees.

The panel rerejected the use of general revenues to finance social security, essentially for three reasons. First, general revenues are more appropriate for needs-related income programs and general tax relief to low-income workers. Second, other needs of the elderly—such as housing, long-term care, and social services—appear to have a more urgent claim on general revenues than income maintenance requirements. Third, the use of general revenues would weaken the wage-related features of social security and may even jeopardize the long-range stability of the entire social security system.

C. Long-Range Considerations

Nearly one-half of the projected long-range actuarial deficit is because the existing cost-of-living adjustment mechanism is particularly sensitive to high rates of inflation. For today's workers, it can actually produce a double adjustment in terms of their future benefits: one to rising wages and another to rising prices. As things stand now, social security benefits rise automatically for today's retirees on the basis of price increases, as measured by the Consumer Price Index. Today's workers are also helped by this adjustment because they will receive the advantages of a higher benefit schedule when they retire. In addition, they can expect wage increases. The net impact is that benefit boosts for today's workers are "coupled" with benefit increases for existing retirees. Thus, there is a rising demand for "decoupling."

Both Presidential candidates in 1976 supported the decoupling within the social security system. President Ford proposed to stabilize the relationship between a social security beneficiary's preretirement earnings and benefit level at retirement through a wage index system. This recommendation would eliminate approximately one-half of the long-range financing deficit. Governor Carter recommended a similar course of action, saying:

> My proposal for decoupling would assure to workers retiring in future years benefits which are the same proportion of recently earned wages as are the benefits of workers retiring now. After retirement, benefits should be adjusted to cost-of-living increases. Stabilizing the replacement rate alone will cut the prospective long-term deficit of the social security fund by half.[25]

Governor Carter also emphasized during the campaign that it may be necessary over the long run to raise the contribution rate slightly. One possible alternative would be to accelerate certain scheduled rate increases in the future. Governor Carter would also consider using general revenues.

The Hsiao panel recommended that retirement benefits continue to be increased automatically after retirement in proportion to the CPI, as under present law. However, the panel proposed that benefits for

[25] Page 3 of statement cited in footnote 15.

future retirees be computed using earnings that have been indexed based on changes in price levels during the earnings-averaging period—instead of the wage indexing recommended by President Ford and Governor Carter.

D. Termination of Social Security Coverage by State and Local Governments

Recent news accounts about the actuarial condition of the social security program have created anxiety and concern for today's and tomorrow's retirees. Many believe that social security is threatened with bankruptcy, although leading experts are in agreement that the financing problems confronting social security are clearly solvable and will, in fact, be corrected.

One manifestation of this concern is the substantial increase in the number of governmental units filing notices to terminate coverage. State and local governments now have the option to elect social security coverage for their employees. Coverage is not compulsory because the Constitution prohibits the imposition of a Federal tax on State and local governments without their consent. Coverage can be terminated, but governmental units must provide 2 years' notice to the Social Security Administration. Once coverage is terminated, it can never be provided again for present or future employees of any government electing this course of action.

To obtain more information about the impact of the recent social security terminations, the Committee on Aging prepared a working paper [26] in September. The report noted that social security coverage for State and local governmental employees more than doubled from June 1961 to June 1975, increasing from almost 3 million to 8.7 million. Nearly 7 out of 10 State and local government employees are covered under social security. However, the working paper pointed out that notices of terminations were clearly on the upswing:

> Nearly 31,000 State and local government employees had their coverage terminated by June 30, 1975. Latest figures reveal that potentially 469,000 employees may terminate their social security coverage from July 1, 1975, to April 1, 1978. This represents a fifteenfold increase, compared with the terminations before June 30, 1975.[27]

Terminations not only have a profound effect on the social security trust funds but also for the affected workers and their families. In his preface, Senator Church said:

> The committee is concerned . . . about the increased number of governmental units electing to terminate coverage, particularly in terms of the financial effect on the system. And the committee is especially concerned about the impact of this decision upon individual workers and their families.[28]

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[26] *Termination of Social Security Coverage: The Impact on State and Local Government Employees*, a working paper prepared by the U.S. Senate Special Committee on Aging, 94th Cong., 2d sess., September 1976.
[27] Page 4 of working paper cited in footnote 26.
[28] Page iii of working paper cited in footnote 26.

> The decision to maximize take-home pay now may be at the cost of losing future retirement, disability, survivor, and hospital protection.[29]

Senator Church emphasized that many workers have difficulty in comprehending the true value of social security because projections about future protection are not always readily available. In addition, large numbers view social security as a retirement program for older workers. The report, though, stressed that social security is family security, protecting workers and their families from loss of earnings because of death, retirement, or disability. The working paper provided several examples to illustrate the value of social security protection, including:

—Social security protection is worth $85,200 in the case of a worker who (1) reaches 65 upon retiring in January 1976, (2) has average monthly earnings of $585, and (3) has a 62-year-old wife.

—The value of survivors and disability protection is $116,380 for a 35-year-old man becoming disabled in mid-1976 who (1) has a 32-year-old wife and two children aged 3 and 5, (2) has average monthly earnings of $600, and (3) dies after being disabled for 5 years.

—The average lifetime value of hospital insurance benefits for a couple, both of whom are 65 years old, is $24,000.

The report also discussed several reasons for the upswing in terminations. Among the major reasons cited:

(1) Employees typically desire more take-home pay to cope with inflation. Thus, many opt for a raise in their take-home pay by reducing their payroll deductions.

(2) State and local governments are oftentimes financially hard pressed. All alternatives to cut costs are now examined, including dropping social security coverage.

(3) Some workers believe that social security is going broke.

(4) Administrators believe that social security payroll taxes will continue to rise, and the amount of future increases is beyond their control.

(5) Employees can still be eligible for social security by "moonlighting" or working in covered employment after leaving government.

(6) The decision to continue or terminate social security coverage is frequently made in a haphazard manner with very little understanding of the important ramifications.

To help governmental employees evaluate the advantages of social security and other forms of coverage, the working paper includes a checklist of important considerations. In addition, the report proposes several actions to assure that the decision to continue or terminate social security coverage is based upon full, complete, and accurate information. Major recommendations include:

—State and local governments contemplating termination of social security coverage should require an actuarial evaluation of the replacement plan by an enrolled actuary.

—The evaluation should consider benefit structure, entitlement factors, vesting (the nonforfeitable right of an employee to receive

[29] Page iv of working paper cited in footnote 26.

a pension after working a specified number of years for a particular employer), portability (the ability to transfer covered work credits from one job to another), evaluation of present and future benefit amounts, cost, replacement ratios, and a comparison of essential benefit protection.

—Any termination of coverage would require an employee referendum after adequate time has been provided for employees to study and compare the actuarial evaluations.

VI. THE COMPELLING CASE FOR AN INDEPENDENT SOCIAL SECURITY ADMINISTRATION

Social security now affects almost every family in the United States. Nearly 33 million persons—one out of every seven Americans—receive social security benefits each month. More than 100 million workers are expected to pay into social security in 1977. In return they will build future retirement, survivor, disability, and hospital protection for themselves and their families.

Besides administering the cash benefit program, the Social Security Administration is responsible for other programs affecting aged and disabled Americans, including medicare and supplemental security income. These facts underscore the importance of assuring that social security, medicare, and SSI are administered impartially and effectively.

In the past two annual reports, the committee has recommended that the Social Security Administration be reconstituted as an independent, nonpolitical agency outside the Department of Health, Education, and Welfare. Senator Church introduced legislation—the Social Security Administration Act, S. 388—during the 94th Congress for this purpose. S. 388 would: (1) Reestablish the Social Security Administration as an autonomous agency under the direction of a three-member governing board appointed by the President with the advice and consent of the Senate; (2) prohibit the mailing of notices with social security and SSI checks which make any reference whatsoever to Federal elected officials; and (3) remove the transactions of the social security trust funds from the unified budget. The committee again urges that legislation to implement this objective be enacted into law early in the 95th Congress, for the following reasons:

—Social security has clearly evolved to the point where it is large enough and important enough to enjoy independent status. It has 1,300 offices conveniently located throughout the country. And it represents one of the larger direct line operations of the Federal Government.

—Independent status would help to improve the efficiency of the Social Security Administration. An independent agency under the direction of a three-member governing board would permit full-time, nonpolitical executive attention. In the past, social security's policy operations have been hampered because of the rapid changeover in Secretaries at HEW and their staffs—12 Secretaries since 1953.

—An independent Social Security Administration would also be advantageous from the standpoint of HEW, which many authori-

ties believe is unmanageable and unwieldly by virtue of its size, budget level, and diversity of programs. HEW could be reduced to more manageable proportions if the Social Security Administration would become a separate unit.

—An independent agency would also underscore in the public's mind the crucial difference between social insurance programs, such as social security, and the general revenue operations of the Federal Government. Social security is basically a self-financing program through payroll contributions by employees and their employers. Money contributed to social security can be used only for two purposes: Payment of benefits and the administrative expenses of the program.

FINDINGS AND RECOMMENDATIONS

Inadequate income in retirement is the No. 1 problem affecting Older Americans. The existing poverty thresholds understate the dimension of deprivation now facing the elderly. One alternative measure of poverty considered by the poverty studies task force—which reflects revised nutritional requirements and a new multiple for income to food—provides a more realistic benchmark of poverty among older Americans.

Under this definition, more than 6 million persons 65 or older would be classified as poor, or almost double the number under the existing official thresholds. A nation as wealthy as the United States has the capacity to abolish poverty for the elderly. But what is needed is the commitment and a comprehensive action plan.

The committee urges that the income standards under the SSI program be raised to a level to abolish poverty for older Americans. In addition, the countable resource limitation for SSI—now $1,500 for a qualifying individual and $2,250 for an eligible couple—should be updated.

The committee supports the need for an extensive outreach effort to seek out potential SSI recipients and educate them about the benefits of this program and their possible eligibility.

Further cooperative agreements between the Social Security Administration and other agencies administering pension programs (e.g., the Veterans Administration and Railroad Retirement Board) are encouraged by the committee for purposes of determining accurate information about SSI recipients' other "unearned income." Such cooperation could lead to fewer underpayments, overpayments, and payments to ineligible persons.

The committee strongly recommends that States pass along the entire cost-of-living increases to their recipients.

The committee urges the new administration to support further studies analyzing the actual adequacy of the SSI benefit. These studies could build upon the work of the supplemental security income group created by HEW Secretary Weinberger in 1975.

The committee strongly recommends that steps be taken early during the 95th Congress to reduce the short-term and long-range deficits now facing social security. The social security cost-of-

living adjustment mechanism should be "decoupled" in the most equitable way possible, and benefits for future retirees should be computed on the basis of a wage-indexed system.

Until the financial integrity of the trust fund is restored, the committee urges that any immediate changes affecting social security be high yield and low cost.

Major improvements are still needed to strengthen social security's essential protection for the elderly, including:

—A special index should be established to measure more accurately the impact of inflation upon older Americans for purposes of computing cost-of-living adjustments.

—Social security should provide two cost-of-living increases during periods of accelerated inflation.

—The age-62 computation point for men should be applied to individuals born before 1913.

—The cost-of-living adjustment mechanism should be made applicable to special minimum beneficiaries.

—The social security earnings limitation should be liberalized.

—Legislation should be enacted to equalize treatment between men and women under social security to assure that the contributions of women generate as much in benefits for their family members as the contributions of men.[30]

State and local governments contemplating termination of social security coverage should have an independent actuarial evaluation of proposed alternative plans to provide employees with essential comparative information about benefits under social security and a substitute plan. Any termination of coverage should require an employee referendum after adequate time has been provided for employees to study and compare the actuarial evaluations.

The Social Security Administration should be reestablished as an independent agency outside the Department of Health, Education, and Welfare.

Adjustments should be made in VA pensions and other Federal benefit programs to assure that elderly persons will not suffer a loss in income because of social security cost-of-living increases.

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[30] For more detailed information, see the Committee on Aging's working paper, *Women and Social Security: Adapting to a New Era*, prepared by the Task Force on Women and Social Security, 94th Cong., 1st sess., October 1975.

CHAPTER II

HEALTH COSTS AND PROBLEMS IN MEDICAID AND MEDICARE

Major problems still remain—as indicated by the previous chapter—in this Nation's retirement income programs.

Undoubtedly, the number of dollars coming into older Americans' households every month is a major factor in determining security, satisfaction, and even survival.

But two other large influences are the adequacy and appropriateness of the help offered by medicare and, for low-income persons, medicaid.

Medicare has done much to improve access to c rtain kinds of health care. Medicaid is helpful in filling some gaps not covered by medicare.

But both programs stand in need of reevaluation as a new administration begins and as interest deepens in a national health insurance program for all age groups.

Medicare's share of the total health costs of the elderly went up to 42 percent in 1975 after a long period of slippage from its all-time high of 43.9 percent in 1969. But much of the 1975 increase reflected a 15 percent rise in hospital costs after price controls in the health care industry were removed in April 1973.[1] Medicare's share of nursing home costs continues to decline, and serious questions per..ist about its limited coverage of prescription drugs and important outpatient or in-home services which would help older Americans stay out of institutions.

Medicaid, also hard hit by rising costs, is constricting the range of services largely through actions by State legislatures.

Overshadowing the limitations and recurring questions about the overall scope and purposes of the two programs, however, is growing concern about fraud and abuse uncovered in congressional and other investigations. New findings by this committee and other units of the Senate and House raise questions which must be answered with dispatch and with concern about the quality of care offered through both programs.

I. HEALTH CARE COSTS AND THE ELDERLY

Public funds paid only 30 percent of the health care costs of the elderly in 1966, before medicare and medicaid went into operation. In 1975, that share had climbed to 61 percent.[2]

[1] "Age Differences in Health Care Spending, fiscal year, 1975," p. 19, by Majorie Smith Mueller and Robert M. Gibson, Social Security Bulletin June 1976. The article also provides much of the information used in the following section on health care costs.

[2] The article cited in footnote 1 lists the Government's share as 66 percent (p. 26), but says that it would be 61 percent if medicare premiums were regarded as private expenditures.

Despite this sizable increase, a social security report issued in 1976 says:

> . . . from 1969 to 1975, the medicare share of the aged's overall health bill and its hospital and physicians' care components has been decreasing for a number of reasons. The average length of hospital stay for the older group has been declining by more than 3 percent a year during much of the period 1969–74. . . . As a result, the patient's initial share of the hospital bill—a deductible roughly equivalent to the average cost nationally of a day of care—has become a larger proportion of the total bill and the medicare proportion has become smaller.

The report listed other factors in the decline of medicare's share including:

Medicare coverage of physician's bills is declining, partly because of the increase in the deductible from $50 to $60 in 1973, but the major reason is the number of doctors who refuse to "take assignment" [3] and thus may bill the patient for more than medicare's "reasonable charges." In 1974, the net assignment rate was 52 percent, as compared to 61 percent in 1969.

"As a result," says the report, "a greater proportion of total charges is being met through private insurance, medicaid, or out-of-pocket payments by the patient and a smaller proportion by medicare."[4]

Program limitations continue to raise the costs actually paid by the elderly.

As the report says:

> During the past several years, only about 3 percent of nursing home expenditures have been paid by medicare. By contrast, in 1968, toward the beginning of the program and before controls on the use of skilled-nursing facilities were tightened, medicare covered nearly 16 percent of total outlays for care of the aged in nursing homes. The program does not pay for dental care, out-of-hospital prescribed drugs, or eyeglasses. Because of these program limitations, medicare's share in the financing of the total health care for the aged, has not kept pace with the advance of its share of financing hospital and medical services.[5]

The total impact of these and other factors upon the amount of money actually paid by the elderly and by other sources for hospital and medical care is spelled out in the following table:[6]

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[3] Under assignment, the physician agrees to accept the program's reasonable charge as payment in full. The patient pays no more to the physician than any unpaid deductible amount and 20 percent of the reasonable charge in excess of the deductible.

[4] Page 26 of report cited in footnote 1.

[5] Page 27 of report cited in footnote 1.

[6] Table prepared by Herman Brotman, consultant to this committee. For additional information on health care expenditures and the elderly, see "Every Tenth American," prepared by Mr. Brotman, in this report.

	Total	Direct out of pocket	Third-party payments			
			Total	Government	Private health insurance	Philanthropy and industry
Dollars:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1975	375	128	247	108	132	6
65 and over:						
1966	445	237	209	133	71	5
1975	1,360	390	970	892	73	5
Percent distribution:						
Under 65:						
1966	100	51.1	48.9	19.4	27.3	2.2
1975	100	34.2	65.8	28.8	35.3	1.7
65 and over:						
1966	100	53.2	46.8	29.8	15.9	1.1
1975	100	28.7	71.3	65.6	5.4	.4

A. Additional Costs in 1976

Out-of-pocket costs given thus far in this chapter have been limited to 1975 data, but it became clear in 1976 that they would continue to go up. Participants in the part B (medical care) program were informed of an increase from $6.70 to $7.20 per month. The deductible under part A (hospital) went up from $92 to $104 in 1976, and increased again in 1977.

B. Opposition to New Increases

On September 30 the Department of Health, Education, and Welfare announced a 19-percent hike in the medicare part A hospital insurance deductible (effective January 1, 1977), from $104 to $124. In addition, other patient coinsurance charges—which are based on the hospital deductible—rose by 19 percent on January 1, 1977:

—From $13 to $15.50 per day for patients who are in skilled nursing facilities from 21 to 100 days.

—From $26 to $31 per day for individuals hospitalized from 61 to 90 days.

—From $52 to $62 per day for patients who must draw upon their 60-day "lifetime reserve."

Since medicare became effective in 1966, the in-patient hospital deductible has increased by 210 percent, from $40 to $124. It now represents 57 percent of the average monthly social security benefit ($218) for a retired worker.

Under existing law these increases are mandatory because the part A deductible is adjusted annually according to changes in the average per diem hospital costs covered by medicare.

Senator Church expressed his desire to provide relief for medicare beneficiaries from rising hospital and nursing home costs, shortly after the Department of HEW made the announcement.

He said:

> Ideally speaking, I would like, here and now, to block this 19-percent increase in the deductible and coinsurance charges from becoming effective.
>
> It is time to put a lid on the rising hospitalization deductible, which hits those hardest who can least afford it.

But as a practical matter, it would be impossible at this late date to enact legislation to freeze the part A deductible at $104 in 1977.

However, I plan to introduce legislation early in 1977 to roll back the part A deductible and coinsurance charges to their 1976 levels.[7]

II. FRAUD AND ABUSE: MORE COSTS, LESS SERVICE

> ". . . the best way to assure quality health care for all older Americans is a step-by-step improvement of medicare. I believe that the immediate need now is to get medicaid under control with an eye toward replacing it with something better."
>
> —Senator Frank Church, September 1976.[8]

Throughout 1976, the Committee on Aging continued its inquiries into fraud and abuse in the medicare and medicaid programs. Several investigations were conducted by Senator Frank E. Moss [9] and his Subcommittee on Long-Term Care which led to startling conclusions about the scope of the problem. These conclusions were presented at Senate hearings, and ultimately helped assure passage of legislation creating the Office of Inspector General in the Department of Health, Education, and Welfare.

A. Clinical Laboratories

In February 1976, a staff report, "Fraud and Abuse Among Clinical Laboratories," summarized a 6-month investigation conducted in five States. The report concluded:

> In practical terms any medical testing laboratory which is so inclined can bill medicaid for a patient a doctor has never seen, for blood never drawn, for tests never performed, at a rate exceeding four times cost and twice the prevailing charge for private paying patients, with nearly absolute assurance that they will not be caught and prosecuted.

The report adds that kickbacks are widespread between laboratories and medicaid shared health facilities, which have been characterized as "medicaid mills." The average kickback paid to the medical center was found to be about 30 percent of the total the laboratory received from medicaid. Kickbacks sometimes took the form of cash, long-term credit arrangements, gifts, supplies, and equipment. Most commonly, it took the form of a supposed rental of a small space (offtimes a closet) in the medicaid medical center.

The report adds:

> The full dimensions of medicare and medicaid fraud with respect to clinical labs are unknown. However, it is the com-

[7] Congressional Record, Oct. 1, 1976, p. S18016.
[8] Congressional Record, Sept. 16, 1976, p. S15992.
[9] Senator Frank Church, committee chairman, has announced that he will continue the committee investigations. He conducted hearings on medicare-medicaid fraud and abuse on November 17, 1976, and March 8 and 9, 1977.

mittee's judgment that at least $45 million out of the $213 million in medicare and medicaid payments for clinical labs is either fraudulent or unnecessary.

B. Boarding Homes

At Senate hearings in New York City on March 19, Senator Moss released the results of the committee investigations into the new and growing for-profit boarding home industry, which is attempting to capitalize on the escalating discharge of thousands of mental patients from State hospitals into smaller, community based facilities. As in the study of clinical laboratories, Senator Moss played a direct role in the investigation, accompanying the staff on visits to boarding homes in New York City and Chicago, Ill. The Senator announced these findings:

> I have visited the psychiatric ghettos of Long Beach and Far Rockaway, N.Y. I have toured several of the old hotels and boarding homes where thousands of former mental patients live. I have seen their world of cockroaches and peeling wallpaper, of flaking paint and falling plaster.
>
> I have seen the broken windows letting cold air into rooms without radiators. I have seen holes in the ceilings of patients' rooms and I have seen roofs that leak. I have seen exposed wiring, overloaded sockets, and fire extinguishers that haven't been inspected for years. I have seen steep staircases with low clearance, and makeshift doors made out of cardboard and burlap.
>
> * * * * * * *
>
> It became evident to me that operators were cutting corners in order to be able to maximize profits. SSI pays $386 per patient per month in New York. This flat payment means there is no accountability. Whatever is not spent becomes profit. Apparently, former mental patients are as good an investment in New York as we found them to be in Illinois. In that State, one operator received $385,000 to care for about 100 former patients. He kept 13 percent of patient income (over $50,000) as profit. Another increased his investment (equity) in an old hotel from $10,000 to $250,000 in 10 years. He housed about 180 former mental patients, receiving $400,000 a year and managed to keep $185,000 in profits (fully 46 percent of total revenues). One of the ways in which he accomplished this was to spend 58 cents per patient per day for food. A third partnership received over $1 million to care for ex-inmates and kept 30 percent of it, over $300,000, as profit.
>
> Given the marginal quality of life that we found in these facilities in New York and all over the United States, I have every reason to believe that other operators are making similar profits. Since the source of these funds is primarily SSI, the new Federal welfare program for the aged, I in-

tend to do everything in my power to restore some accountability to this program. The taxpayers deserve to know how their money is being spent. Right now it looks as if much of the funds are going to line the pockets of the greedy who pretend to be offering services to the needy.

C. Physician Fraud

Senator Moss testified before the Senate Finance Committee on July 28, 1976, on fraud and abuse among practitioners in the medicare program. He reported on an evaluation of the files of medicare's program integrity unit. Committee on Aging staff reviewed every case referred to the Department of Justice for prosecution for 25 States from 1969 through June 1976. In addition to this data, examples of physicians fraud documented in other related investigations of nursing homes, clinical laboratories, or home health agencies were provided.

Senator Moss said that although medical practitioners accounted for a large portion of the suspected fraud and abuse cases in medicare case files (49 percent of suspected fraud and 73 percent of abuse cases) the number of physicians who cheat the system is small. Senator Moss offered the estimate that 4 percent of all medical practitioners (including chiropractors, podiatrists, osteopaths) may commit fraud. This statistic was a projection based on the assumption that medicare files contain at least 400 apparently irrefutable cases against such practitioners out of the 9,907 complaints being investigated. The Senator concluded:

> *The chances that a physician will be caught cheating the medicare program are very slim indeed*, even given the good work of medicare's program integrity unit. *The chances that a case will be developed are slimmer still;* most of the existing cases relate to charging for services not rendered—that variety of fraud which is the easiest to prove. *The odds that a case will be referred to the Justice Department for prosecution are extremely small* (only 400 cases of physician fraud have been referred to Justice since 1969 or roughly 4 percent of all physicians' fraud cases). *The chances of being found guilty are infinitesimal* (since less than 1½ percent of all accused in physicians' fraud cases have been found guilty). *The chances of a physician going to jail for medicare fraud are less than infinitesimal* (only 15 doctors have served some time in jail as a consequence of medicare fraud since the very beginning of the program 10 years ago). *The chances of having a license revoked or being terminated from the medicare program are nonexistent* (we found only two physicians who had their licenses revoked and none have been terminated from the medicare program since its beginning in 1965).
>
> It is obvious that *the great majority of physicians who are caught abusing the system are simply asked to pay back the money* (or some portion of it) *that they have stolen.* Even those that are indicted on as many as 60 or 70 felony counts are allowed to plead guilty to one or two misdemeanor counts

upon a promise to repay moneys fraudulently obtained. In some cases minor fines are involved. *Significantly, both these repayments and any fines leveled at the practitioner for fraudulent practices are almost invariably paid out of future medicare earnings.*

D. Medicaid Mills

In October 1975, the Illinois Physicians Union, together with the Illinois Medical Society and the Chicago Medical Society conducted a meeting which was attended by two members from the committee staff. It was at that meeting that the committee received its first details about so-called medicaid mills. The physicians present at that meeting were outraged by what they viewed as common practices in urban ghettos: entrepreneurs who owned or leased a building would hire foreign medical practitioners, including psychiatrists, chiropractors, medical doctors, and dentists—all of whom would work out of a shared-health facility. The owner took charge of all the billing for the doctors. Most commonly, the agreement called for the practitioners to keep only a small percentage of the money they received from medicaid for treating patients. In some instances, the foreign medical doctors received only 30 percent of their earnings. Moreover they were pushed by the landlord to see more and more patients in less and less time, hence the title "medicaid mill."

The Illinois doctors had just completed a peer review of the practices of several high volume medicaid practitioners. They were outraged about the poor quality of medical care being offered under the above circumstances. As noted above, the committee staff soon had direct contact with medicaid mills, and practitioners who worked in them, in the course of the investigation of clinical laboratories. It was the laboratory fraud investigation which pointed to the necessity of an in-depth investigation of the practices of medicaid mills. Five States, which received more than 50 percent of all medicaid funds, were chosen for the investigation: California, New York, New Jersey, Michigan, and Illinois.

The staff report adds:

> New York was singled out for in-depth analysis for several reasons: (a) it has the largest medicaid program in the Nation, spending an average of $180 per inhabitant while the national average is $66 per inhabitant; (b) New York accounts for almost 25 percent of total medicaid outlays despite the fact that New York has less than 9 percent of the country's population; (c) the New York program historically has been charged with being the worst managed in the Nation; and (d) because of the apparent relationship between the mismanagement of the program and New York's current fiscal crisis.
>
> In the course of this investigation, the following steps were taken in an effort to ascertain as accurately as possible the size and dimensions of the problem and to determine what remedial steps are necessary. Senate investigators attempted to test the system from three perspectives: government, provider, and patient.

Specifically, the investigation involved the following:

(1) Examining in detail more than 100 major reports produced by Federal, State, or local agencies detailing fraud, waste, or inefficiency in the medicaid program with particular emphasis on New York.

(2) Reviewing records in the New York City Department of Health, in the office of the U.S. attorney for the southern district of New York, and the District Attorney's Office for New York County, as well as in the offices of Michigan's Post Payment Surveillance Unit—the so-called Fraud Squad.

(3) Manually evaluating the medical vendor statement—a computer printout—compiled from payment records of the New York City Department of Social Services.

(4) Interviewing 20 public officials and sending written interrogatories to 30 additional public officials with present or past responsibility for the operation of the medicaid program in New York.

(5) Interviewing more than 60 physicians who work in or own "medicaid mills" (50 were Illinois physicians interviewed in January in connection with our report on clinical laboratory fraud).

(6) Sending questionnaires to the 250 physicians in New York who were paid from $75,000 to $785,000 by the medicaid program last year.

(7) *Posing as medicaid beneficiaries and entering more than 100 so-called medicaid mills, committee staff presented themselves for treatment some 200 times. More than 120 of these visits were in New York City. The remainder were in California, New Jersey, and Michigan.*

(8) Announcing establishment of a corporation for the ostensible purposes of buying and operating health care facilities. Accompanied by cooperating physicians, investigators answered advertisements in the New York Times, noting medicaid mills for sale in Manhattan, Brooklyn, Queens, and the Bronx. This technique, along with our interviews of the 50 physicians in Illinois, gave us direct information as to the financial operation of numerous medicaid mills.

(9) Monitoring the operation of a storefront medical clinic established last December by Chicago's Better Government Association.

Senator Moss posed as a medicaid patient (with the assistance of law enforcement officials, as was the case with other investigations) to experience firsthand the poor care, and the excessive testing which characterizes such facilities. Like the other Senate investigators, he was given many unnecessary tests and referred to other practitioners simply on the basis of his feigned cold.

In Senate hearings on August 30 and 31, Senator Moss, committee staff members and temporary investigators provided sworn testimony of their experiences in medicaid mills.

A staff report prepared for those hearings concluded:

> Based on the findings of this investigation, committee staff and investigators conclude that rampant fraud and abuse exists among practitioners participating in the medicaid program and that such fraud and abuse is matched by an equivalent degree of error and maladministration by Government agencies. The scope and degree of these problems is most acute in New York and is commensurate with its having the largest medicaid program of any State in the Nation—$3.2 billion and 23 percent of the national expenditures annually.
>
> *It appears to the staff that the current manner in which medicaid is administered discourages reputable medical professionals from participating in the program. The result is the dominance of the medicaid program by a small number of practitioners who, in league with a handful of real estate operators and other businessmen, often with substantial political influence, have substituted entrepreneurial expediency for Congress' original aim of using medicaid to deliver adequate health care to the needy at a reasonable cost.*

E. State and Federal Prosecutors

On November 17, Senator Church conducted a hearing at which State and Federal prosecutors testified. Samuel K. Skinner, U.S. Attorney for the Northern District of Illinois, called medicaid "the greatest ripoff in history." *He said he would not be surprised to find that 20 or 25 percent of the $17 billion program represented fraudulent payments.* He underscored the serious problem of the lack of trained investigators and Assistant U.S. Attorneys in his office. He stated he had to divert badly needed resources in order to prosecute medicare and medicaid fraud cases (including several generated by the committee's investigations of clinical laboratories).

Mr. Skinner commended Senator Moss for his work in the area of fraud and abuse, stating his regrets that Senator Moss had been defeated in a bid for re-election.

Senator Moss said: "Much good has been done, but very much remains to be done to protect our elderly, our sick, and our poor."

Senator Frank Church joined in praising Senator Moss. He assured Senator Moss that the work he and the Subcommittee on Long-Term Care had begun would be continued. The chairman indicated his personal commitment to elimating medicare and medicaid fraud.

Charles J. Hynes, special prosecutor for nursing homes in New York, testified that he was the recipient of literally truckloads of nursing home records which the Subcommittee on Long-Term Care had subpoenaed in connected with its January 1975 hearings. Since that time, he has announced more than 150 indictments and has obtained some 30 convictions.

At the hearing, he announced that his office had uncovered a massive kickback scheme involving half of the nursing homes in New York City and vendors who serve them. He noted that his office had identified $70 million worth of nursing home fraud in New York City, and his auditors had recovered $2,500 for every man-day of effort. He told the

Senators that medicaid fraud is "massive." He said fraud schemes are so complex that a separate division in the Department of Justice is needed entirely for health care fraud. Mr. Skinner agreed with Mr. Hynes' statement that to cope with the problem effectively, "a massive Federal effort is needed."

Soon after the hearing, Congress passed legislation authorizing the Office of Inspector General in the Department of Health, Education, and Welfare. This new officer will be charged with maintaining the fiscal integrity of all 334 HEW programs. Report languages accompanying the legislation makes it clear that a major effort will be directed at medicare and medicaid fraud. Legislation has been introduced by Senator Herman Talmadge which would outlaw "factoring," [10] the practice of selling medicare or medicaid accounts receivable for cash less a discount, and would increase penalties for medicare and medicaid fraud, making them felonies instead of misdemeanors. Still other legislation is being prepared by Senators Church and Pete V. Domenici along the line suggested by the State and Federal prosecutors.

Senator Church, in a floor statement summing up his reasons for supporting Senator Talmadge's bill, said that some Members of the Congress had expressed concern when enacting medicaid in 1965:

> At that time, many of us had grave reservations about the feasibility of an administrative system which divided the responsibility for control among Federal and State authorities. However, we were more than willing to take a chance on medicaid because it had the potential to make quality care available to the needy.
>
> In part, we have seen our hopes fulfilled in the last 10 years. Medicaid, as well as medicare, has rendered necessary services to the poor, the elderly, and the disabled. Unfortunately, our concerns for the medicaid program have been justified as well. The States and Federal Government have continually pointed accusing fingers at each other. Both parties should have some responsibility under the law; neither has accepted any. The Subcommittee on Long-Term Care, chaired by Senator Moss, has repeatedly documented areas of fraud and abuse by nursing homes and home health agencies, by clinical laboratories, and by practitioners in the program.
>
> Nor has Senator Moss's subcommittee been alone in its important work. Other committees of Congress have produced similar findings. The U.S. General Accounting Office has issued several reports which noted the lack of Federal action, specifically by the Department of Health, Education, and Welfare, in forcing States to comply with medicaid requirements. The recent hearings conducted by the Subcommittee on Long-Term Care, then, dramatic as they were, must be seen within the context of old, not new, abuses of the program.

[10] For a discussion of factoring companies, see p. 105 of *Developments in Aging: 1975 and January-May 1976*, part 1.

III MISTAKEN PRIORITIES?

A physician testified before HEW:

> . . . problems in the provision of home health care are merely symptomatic of the broad disarray in the health care system generally, of the tremendous financial burden illness imposes upon the public, and the lack of leadership of public bodies in resolving the many problems that face us at this time . . . those people who are chronically ill or homebound, who are not going to be rehabilitated, who may be in terminal illness, or in other ways disabled, are the people which the system deals least well with on an ongoing basis and are the people who need the most assistance.[11]

Medicare is generally regarded as oriented toward the treatment of acute illness, and the value of its protection in this regard cannot be minimized.[12] But chronic illness is a day-in and day-out reality for millions of elderly persons, who are more than four times as likely to have their activity limited by chronic illness than younger persons.[13]

Another measure of the extent of disability among the elderly is the fact that in 1975 there were twice as many elderly bedfast and housebound in the community as there were elderly residents in institutions of all kinds, 10 percent compared to 5 percent, or 2 million compared to 1 million.

This finding has been construed to suggest that medicare has not reduced the proportion of the elderly living in the community who are bedfast or totally housebound, because the percentage is similar to that which existed before medicare took effect.[14]

If 2 million older persons are now homebound and likely candidates for expensive institutionalization, if current arrangements fail, what more can be done to assure that they remain at home—and receive needed care—than is now the case? And what of the future, when even higher proportions of persons in the very highest age brackets can be expected?

Answers to those questions are being sought with increasing urgency in studies and statements which question whether medicare or any other program can deal with such problems, merely by making payments and doing little to encourage forms of care and treatment more responsive and appropriate to the actual needs of the elderly.

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[11] "Home Health Care: Report on the Regional Public Hearings," HEW, Oct. 29, 1976, p. 4.

[12] Studies by Avedis Donabedian, M.D., Public Health Reports, July–August 1976 (pp. 322–330) indicate that the advent of medicare and medicaid resulted in the increased use of physicians' services by low-income and aged persons, previously deprived of care. Further, these programs have favored the nonelderly in the use of physician services outside the hospital, and favored the aged on the use of inpatient hospital care.

[13] "Limitation of Activity and Mobility Due to Chronic Conditions, United States, 1972," National Center for Health Statistics, 1974.

[14] Ethel Shanas, Ph. D., and professor of sociology at the University of Illinois at Chicago Circle, came to this conclusion in a paper presented in October 1976 at the annual meeting of the Gerontological Society, New York City. She compared findings from national probability sample studies of the noninstitutionalized elderly in spring of 1962, 4 years before medicare became effective, and in the spring of 1975, 9 years after the program began operations. She found that the percentage of bedfast or totally homebound in the 2 years were almost identical. Her paper stated: "It is chronic disease and incapacity of the elderly that is reflected in the index of functional capacity used in these surveys. Medicare has not alleviated the ravages of chronic disease nor made the old young. In this area also, medicare, a payment scheme, has made no difference."

What is required, in the words of one author and consultant on health care, is the recognition that "a basic community network of services is essential to the full realization of the potential of the individual components as a system of care, and the realization that effective utilization of the services will be limited when needed elements which are essential to the system are inadequate in kind and quality, limited in coverage, or unavailable." [15]

A. Home Health—Limited Progress

Expenditures for home health services peaked in medicaid in 1971 to 0.48 percent of total expenditures and had decreased by 1973 to 0.28 percent of total expenditures. Medicare payments for home health peaked in 1969 to 1.1 percent and had decreased in 1973 to 0.7 percent.[16]

Some recognition of the significance of those figures was provided by the Department of Health, Education, and Welfare in a summary of five public hearings on home health care during September and October 1976.

According to the HEW summary:

> The primary concern expressed by the witnesses was for an expanded, coordinated range of high quality home services as a part of an essential continuum of health, social, and support services. The greatest consensus about expanded benefits was for broader coverage of homemaker/home health aide services by all third-party payment programs.[17]

The witnesses emphasized that the "need for home services extends well beyond the elderly, to include children and the handicapped and disabled of all ages."

The hearings dealt, too, with the varying levels of care. One witness gave the following description:

> *The acute or intensive level of home care provides services for patients who require active treatment and/or rehabilitation, require a high degree of physician and nursing supervision and management, require centralized and professional coordination of treatment and services, and would otherwise require inpatient hospital care. The intermediate level of home care is necessary for patients who require active treatment and/or rehabilitation, require a reduce level of physician supervision and management, and primarily require nursing care and/or physical rehabilitation and health aide services. Lastly, the maintenance level of home care is appropriate for patients who are reasonably stable medically, have attained a satisfactory level of rehabilitation, require only periodic evaluation and regular monitoring, and need assistance only with daily living activities and supportive personal care services.*[18]

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[15] Page 5, "Adult Day Facilities for Treatment, Health Care, and Related Services," a working paper prepared by Brahna Trager for the U.S. Senate Committee on Aging, September 1976.
[16] Page 37 of reference cited in footnote 15.
[17] Page 1 of reference cited in footnote 11.
[18] Pages 20–21 of reference cited in footnote 11.

Several witnesses objected to the provision of an acute or intensive level of care in the home, others, including major third party payors, supported the concept of providing all levels of care in the home where appropriate. The justification for giving all levels of care in the home was stated by one witness:

> *People tend to move back and forth in a continuum; they don't stay static in their level of functioning and don't need just one service.*[19]

One witness summed up the situation this way:

> *To us, a major problem in the delivery of health care to the aged is that most people view home health care as an alternative to institutionalization. To the contrary, we believe that institutionalization is an alternative to home health care and should only be used as a last resort.*[20]

THE LEGISLATIVE FRONT

Calls for legislative action to promote greater reliance on in-home services were numerous in 1976, and—in one case—there was also a call for action on a program which had been authorized and funded but not implemented.

Demonstration program begins.—Enacted in July 1975, a home health grant demonstration program was so delated in beginning operations that Senator Frank Church asked for a 1-year extension in 1976.

In calling for this action, Senator Church said:

> Most older Americans would prefer to remain at home in familiar surroundings if at all possible. And they can if effective alternatives to institutionalization are available.
>
> But if this is to become a reality, home health services and facilities must be increased. In addition, it is vitally important that there be trained personnel to deliver services to elderly persons.[21]

This extension was incorporated into the Health Maintenance Organization Act of 1976, Public Law 94–640. It authorized $10 million to finance the initial costs of establishing and operating home health agencies and to expand services of existing agencies, along with $5 million for training professional and paraprofessional personnel for home health agencies.

According to Church, the enactment of this measure "takes on added importance now because our Nation can conceivably save $600 million if the medicare national hospital average would be reduced by just 1 day." [22]

On September 17, 1976, HEW announced 56 awards totaling $3 million under the initial home health demonstration grant program. Further awards may be made with additional appropriations during fiscal year 1977.

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[19] Pages 20–21 of reference cited in footnote 11.
[20] Page 10 of reference cited in footnote 11.
[21] Congressional Record, June 18, 1976, p. S 9941.
[22] Reference cited in footnote 21.

Also sought is legislation which would liberalize the home health reimbursement provisions under the medicare program. During the past two sessions of Congress, Senator Church has introduced legislation which would do the following:

—Remove the requirement that only "skilled" nursing care or physical or speech therapy would qualify as reimbursable home health services under medicare;

—Broaden medicare coverage to include homemaker services; and

—Increase the number of reimbursable visits from 100 to 200.

This legislation, S. 2713, has not been enacted.

Similar proposals are being advanced in the House of Representatives by Congressman Pepper, chairman of the House Select Committee on Aging, and Congressman Koch (H.R. 1116 and H.R. 453 of the 95th Congress respectively).

In addition, Congressman Pepper has introduced legislation (H.R. 1126) which would expand reimbursement for medicaid home health services and provide grants under the Public Health Service program for the development and expansion of home health services.

B. Adult Day Facilities

Health and other services need not necessarily be delivered to the person in need of them. More and more in the United States, persons suffering from chronic illness can be brought to the services they need.

A report released by the Committee on Aging in 1976 summarized the progress made toward that goal, as well as several of the barriers to such progress.

A preface to the paper—submitted by Senators Church, Williams, Kennedy, and Moss—agreed with the author, Ms. Brahna Trager, that what is needed is:

> . . . a more responsive and comprehensive community-based system in which a number of options are available to those who need assistance to maintain semi-independence, in which the full-time institutional bed is there when needed but not called upon unless it is in the patient's best interest to do so.[23]

Day health facilities for the elderly provide one such option. As broadly described by Ms. Trager, they:

> . . . provide for group care during the day in a safe, comfortable environment in which selected therapeutic and personal care services, good food, and social opportunity are offered by professional and paraprofessional staff which has both special training for and special interest in the objectives of this method of care and in the individuals to whom it is adapted.
>
> A day center for health and related services to adults who have physical and other limitations utilizes the individual's "own bed" and sustains his relationship to the environment which he considers his home. That home may be with a spouse; with members of his family; with friends or in a group living

[23] Page IV of reference cited in footnote 15.

arrangement; in a place where he is living alone; and in rarer instances, in a facility which utilizes the center to provide for transition from an institution to community living.[24]

Ms. Trager says further:

> The development of adult day centers as a community service is relatively new in the United States and has presented a variety of approaches affected by funding, by what has been seen as the first priority in community need and by the availability of community resources. Emphasis on treatment or rehabilitation occurs in varying degrees; "health related" services are variously interpreted as well.
>
> Virtually all centers which have been reviewed formally, do, however, stress effective services which support and maintain the person . . . the profile of participants in almost all centers indicates that individuals whose handicaps are severe enough to require a variety of coordinated services can be maintained in the community—many of them in age ranges and with physical and psychological limitations which might otherwise require institutional care which is not as well adapted to their needs . . .[25]

Such "needs" may include everyday skills for self-sufficiency. As one occupational therapist described her goal:

> My major objective is to make every movement useful. If I can help that woman extend her arm and grasp with her hand, I'm going to make it possible for her to extend her arm and grasp a can of beans.[26]

Fragmented funding constitutes a major obstacle to the provision of day health services for the elderly.

Ms. Trager indicates that:

> . . . three titles of the Older Americans Act (III, IV, VII) have provided funds for some services in some centers through Federal, State, and local levels of government; three titles (VI and XVI and more recently XX) of the Social Security Act; model cities and revenue-sharing moneys have been tapped; medicare and medicaid have paid for eligible services; a variety of community organizations—United Way, in some instances private insurors—have paid for services; and in-kind and volunteer services have been utilized. Participant fees make up a relatively small proportion of revenues.[27]

The report indicates that "the per diem or per patient costs vary as widely as policies and services and are, of course, the result of this variation." A range of $3.50 to $33 per day was reported by Ms. Trager, excluding a day hospital program with higher costs.

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[24] Page 10 of reference cited in footnote 15.
[25] Page 22 of reference cited in footnote 15.
[26] Page 17 of reference cited in footnote 15.
[27] Page 21 of reference cited in footnote 15.

One interviewee points out, however, that:

> . . . cost alone should not determine whether day care is a viable alternative to institutional care. More important should be the issue of the person being served and the ability to keep him a part of the community as long as possible. The self-respect of the individual who knows that at the end of the day he will be returning home is another great factor in support of day care. Institutionalization for many means the end of the line. Day care still offers hope.[28]

The overall role of day care in a spectrum of services was reiterated by Theodore Koff, associate professor, University of Arizona:

> The primary essential is that [they] be a part of a *sequence* of services so that the individual can move in and out of the various service settings. . . . The extent to which there is a community support system which insures appropriate choice; awareness of health needs; central intake; coordination in planning and placement; transportation, and other such services, insures the success of each section of the sequence . . . the centers are a *part* of a system; they are not the *entire* system. Their use must be very flexible, depending on community perception of need. There is no single approach but the principles and standards must provide for quality—in professional services, in training—and for flexibility—for movement *out* as well as in.[29]

IV. NATIONAL HEALTH INSURANCE: FIRST STEPS

Speculation about a national health insurance program in the United States has been kindled anew by the inception of a new administration.

Quite clearly, the advent of national health insurance will have important consequences for the Nation's elderly. It can provide an opportunity to build upon medicare. Or, it can ignore the important lessons of our Nation's first major health insurance program for older Americans, regardless of income.

Arthur E. Hess, former Deputy Commissioner of the Social Security Administration, said:

> The fact is . . . that medicare provides the only significant Federal experience in the large-scale administration of health insurance for an across-the-board population. As a result, medicare has flushed out a host of basic problems and highlighted anomalies in our health care system.[30]

Mr. Hess states further:

> Improvement of medicare now need not be inconsistent with a long-range agenda requiring more sweeping changes. Although some might not agree on an immediate objective

[28] Page 10 of reference cited in footnote 15.
[29] Page 42 of reference cited in footnote 15.
[30] "A Ten-Year Perspective on Medicare," by Arthur E. Hess, Public Health Reports, July-August, 1976, p. 299.

of making the medicare program more all-inclusive for those it now covers, all must wish it to be administratively more effective.[31]

The high cost of health care continues to be a major worry of older Americans, despite the valuable protection of medicare. This mounting health care cost squeeze must be resolved if our Nation is to provide for security in retirement.

Several options have been advanced to improve medicare prior to the enactment of a national health insurance program. Two of these options were described in some detail in last year's Developments in Aging—the proposal of the National Council of Senior Citizens and the proposal of the American Association of Retired Persons, introduced in the Senate by Senator Ribicoff.

Senator Church has advanced a third alternative.

A. The NCSC Proposal

NCSC recommended several improvements in medicare until new national health security becomes a reality, including the merger of medicare and medicaid as a federally administered program.

Part A and Part B would be combined and the premium charge under medicare part B would be terminated. Coinsurance and deductibles would be eliminated, and such services as outpatient drugs, eye care, and hearing care would be covered. Some portion of the cost of coverage would be borne by general revenues, and the remainder by payroll taxes.

B. The Ribicoff-AARP Approach

Like the NCSC approach, this proposal would provide more comprehensive benefits for elderly persons under the medicare program and would extend coverage to all persons 65 years of age and older regardless of insured status. Further, it would (1) combine part A and part B of the program into a single, expanded benefit structure with a single trust fund, (2) establish coinsurance payments on a sliding fee basis (eliminating premium payments and deductibles), (3) require participating physicians to accept assignment, and (4) provide an income-related catastrophic ceiling on health expenditures.

C. Another Blueprint for Action

In autumn 1976, Senator Church recommended to Democratic nominee Jimmy Carter a step-by-step approach to develop a more comprehensive medicare program, to be incorporated eventually into national health insurance. Senator Church pointed out that medicare could be the model for a new national health insurance program. Among the major steps in his phased implementation program:

Step One.—Elimination of fraud and abuse in medicare and medicaid. Initial legislation has already been enacted (Public Law 94–552) which would establish a central fraud and abuse unit within the Department of Health, Education, and Welfare to provide investigative support to Federal and State prosecutors and impose more severe

[31] Page 362 of reference cited in footnote 30.

83-453 O - 77 - 5

penalties for fraudulent practices. (Discussed earlier in this chapter.) Still, further reform is necessary, and prompt enactment of legislation—introduced originally by Senator Talmadge during the 94th Congress (S. 3205)—would be an important step forward. Such reform could conceivably lead to a savings of $1.5 billion alone in medicare.

Step Two.—Rollback the 1977 increase in the inpatient hospital deductible from $124 to $104, the level in 1976. Senator Church introduced legislation (S. 185) on January 11, 1977 to implement this objective. S. 185 would provide $200 million in relief to nearly 6 million medicaid beneficiaries.

Step Three.—Enactment of catastrophic health insurance for aged and disabled medicare patients, including proposals to:

(a) Limit a patient's liability to $500 for hospital expenses.

(b) Limit a patient's out-of-pocket payments to $250 for covered physician expenditures.

(c) Provide for unlimited hospital and skilled nursing care coverage.

Step Four.—Focus medicare improvements on high priority services, such as coverage of essential out-of-hospital prescription drugs,[32] and expanded home health care benefits.[33]

Step Five.—Make medicare benefits more comprehensive. This would include coverage of:

(a) Optometrist services, eyeglasses, and frames.

(b) Hearing aids.

(c) Dentures, partial plates, professional fees, but no routine work.

(d) Physical exams.

Step Six.—Catastrophic health insurance for all persons similar to the provisions for the elderly along the lines of step three.

Step Seven.—National health insurance. This coverage should necessarily be implemented on a gradual basis, probably in three stages: Limited coverage, broader coverage, and comprehensive coverage.

At some point during this transition it will be essential to authorize the use of general revenues to finance health insurance programs. Until such time, Senator Church recommends the retention of the wage-related feature of employer-employee contributions.

D. Rural Initiatives

Health care in rural areas was the focus of hearings by the committee (see chapter IX). Describing the problems of elderly persons in rural areas, one Iowa physician told Senator Clark, who was chairing the hearings:

> Keep in mind that many of these recipients have a loss of vision . . . live alone, and are totally unaccustomed to business forms and computer correspondence. Further, most really do not comprehend the concept of usual and customary fees, the ever changing level of deductibles and percentage payment of allowable charges and the variability in the per-

[32] Similar to S. 862, 94th Congress, introduced by Senator Church.
[33] Similar to S. 2713, 94th Congress, introduced by Senator Church.

centage of payment for similar services when provided as a hospital inpatient, outpatient, or in the doctor's office.[34]

Further, the physician attested that "the greatest problem facing health care . . . [for] the rural elderly is their lack of physical accessibility to the health care delivery system. . . . Public health programs in the rural Midwest, if left to local government initiative and funding, will remain inadequate at best and too often will be nonexistent."[35]

The physician went on to further describe the problems of attracting physicians to rural areas, and the obstacles in the medicare program for utilizing qualified paraprofessional personnel in these areas:

> Medicare refused to allow reimbursement for physician extenders' services provided in the absence of direct supervision—that is, the physical presence—of the employing physician. This makes it impossible to utilize either a physician's assistant or a nurse practitioner in an efficient and meaningful way to improve the availability of health care in rural areas.[36]

In responding to this problem, Senator Clark agreed to introduce legislation which would allow such services of certified nurse practitioners and physician extenders to be reimbursed by the medicare program provided such care was given in a clinic setting with periodic review by a licensed physician.

In introducing this legislation (S. 708) on February 10, 1977, Senator Clark stated:

> As we all know, rural America is losing its primary care physicians . . . many of the doctors who still practice are approaching retirement, leaving thousands of small communities and millions of Americans with no alternative but to travel many miles to larger cities to receive health services . . . thousands of communities throughout the country are relying upon the services provided by physician extenders in rural health clinics . . .[37]

Senator Church supported Senator Clark's findings and legislative recommendations and expressed dismay that:

> Rural elderly persons receiving care from these clinics . . . are dutifully paying their monthly part B medicare premium—physicians services—[only to find that] they are denied reimbursement for their treatment at the clinic.[38]

The adoption of S. 708 would "correct an injustice in the medicare program without jeopardizing the quality of care for persons in rural areas," continued Church. "If medicare is to serve all persons in all geographic areas with some degree of equity, it is high time for corrective action."[38]

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[34] Dr. Jack Fickel, medical director, Family Care Center, Red Oak, Iowa, in testimony given before the Aging Committee in Winterset, Iowa, Aug. 16, 1976.
[35] See footnote 34.
[36] See footnote 34.
[37] Congressional Record, Feb. 10, 1977, p. S 2523.
[38] Congressional Record, Feb. 10, 1977, p. S 2524.

Additional legislation affecting rural hospitals was introduced by Senator Laxalt in the 94th Congress and reintroduced in the 95th Congress, S. 916. This bill would provide more flexible standards for rural hospitals of 50 beds or fewer under the medicare and medicaid programs. It would allow the Secretary of Health, Education, and Welfare to relax the rules on merging acute and chronic patients in the same facility, such as has been done on an experimental basis in Utah, and allow a rural facility to meet sufficiently stringent State fire and safety codes in lieu of the Federal standards. The measure would also bring personnel requirements in line with the scope of services offered by the hospital and the availability of technical personnel in that area.

According to Senator Church, a sponsor of the proposal, the quality of care in smaller institutions is "severely hampered . . . when the Federal Government imposes standards on the institutions which are inappropriate to limitations of its size and situation." [39]

In other related action, the Congress extended and expanded the Health Manpower Act, Public Law 94–484, enacted on October 12, 1976. This legislation is designed to correct the geographic maldistribution of physicians and dentists, and provides expansion of the National Health Service Corps which provides loans to medical students who agree to serve in rural and underserved areas upon completion of their education. (These loans are subsequently repaid through the service requirement.)

FINDINGS AND RECOMMENDATIONS

Older Americans continued to be burdened by high health care costs—costs that are six times greater than persons under age 19, and three times greater than the 19 to 64 age group.

Medicare now pays for 42 percent of these costs. However, the elderly's per capita out-of-pocket payments amount to $390 a year.

These facts underscore the need to examine the health cost burdens of older Americans and the appropriateness of the care that medicare patients receive. In addition, fraud and waste in the program must be eliminated to insure that the funds are used fully to pay medical and hospital charges of elderly and disabled individuals.

The committee recommends the following action:

—Rollback of the part A hospital deductible to the 1976 level.

—Liberalization of the medicare home health benefits to allow for home health as a viable option in the spectrum of care.

—Establishment of day care benefits under the medicare program to encourage day health facilities as an option for elderly persons.

—The enactment of medicare-medicaid antifraud legislation, as well as expansion and improvement of medicare as a preliminary step to any discussion of national health insurance. Essential out-of-hospital prescriptions should be covered at an early date.

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[39] Congressional Record, March 4, 1977, P. S3482.

CHAPTER III

THE FEDERAL ROLE IN UPGRADING NURSING HOMES

During 1976, nursing home revenues increased sharply totaling $10.5 billion; more than half of this amount are tax dollars. The much criticized medicaid program alone accounted for 50 percent of all nursing home revenues. However, despite the increasing commitment of public funds, thousands of persons are going without the care they need and the quality of care provided in long-term care facilities has not improved to desired levels. Much of the problem is the failure on the part of Government to establish a comprehensive policy with respect to long-term care. Existing Federal standards need to be strengthened and the Department of Health, Education, and Welfare must insist that the States enforce Federal regulations. Hopes for improvements in the quality of care and for the improved fiscal integrity of the medicare and medicaid program are high, as a new administration begins its work.

I. THE GROWTH OF NURSING HOMES

From 1960 to 1976 the number of older Americans in the United States increased 23 percent—from 17 million to more than 21 million. At the same time, the number of nursing homes increased 140 percent, the number of beds by 302 percent, and total expenditures for nursing home care by an unbelievable 2,000 percent. Details follow:

	1960	1976	Percent increase
Homes	9,582	23,000	140
Beds	331,000	1,327,358	302
Patients	290,000	1,000,000	245
Employees	100,000	650,000	550
Dollars (millions)	$500	$10,500	2,000

In fiscal year 1976, medicaid paid $5.3 billion to the 15,569 participating nursing homes. About 8,902 were ICF's (intermediate care facilities); the remainder were SNF's (skilled nursing facilities). These facilities have about 750,000 beds. As noted, medicaid payments represent 50 percent of all nursing home revenues. In fact, the lion's share of that $15.5 billion program went for nursing home care. Specifically, 38 percent of medicaid moneys were claimed by nursing homes. Hospitals were second with 31 percent of the total.

By contrast the medicare payments are small. Medicare paid $314 million to nursing homes in fiscal 1976 or slightly less than 2 percent of the almost $18 billion program. Some 3,928 nursing homes with

309,790 beds were participating in the program (most of these skilled nursing facilities also participate in the medicaid program). The average daily reimbursement to a nursing home was $31 per patient per day.

With the exception of the average per diem payment, these growth figures are down sharply. For example, in 1969, nursing home payments made up 5 percent of total medicare expenditures and there were over 5,000 nursing homes participating. But perhaps the best evidence of the shrinking nursing home benefit is the fact that only 8,300 people in nursing homes have their care paid for by medicare on any given day out of the 1 million patients found in U.S. nursing homes. This is contrasted with the 70,000 in nursing homes on any given day in 1971.

II. THE SUBCOMMITTEE REPORTS

Under the chairmanship of Senator Frank E. Moss, the Subcommittee on Long-Term Care conducted 30 hearings on nursing home problems between 1969 and 1976. The hearings formed the basis for the 12-volume report entitled "Nursing Home Care in the United States: Failure in Public Policy." An introductory report was issued in November 1974, and followed at intervals with a series of supporting papers. To date, seven supporting papers have been issued. These papers are summarized as follows:

Introductory Report—"Nursing Home Care in the United States: Failure in Public Policy"

This report charges that the United States has failed to establish a comprehensive policy with respect to long-term care. Specifically, HEW has been reluctant to issue forthright standards, even though required to do so by the Congress. Existing standards have not been enforced. There is serious fragmentation of responsibility for enforcement on both the Federal and State level. There is a dearth of audits to protect the integrity of Federal health care programs. Finally, the report notes, there is an overemphasis on institutionalization, with little attempt to help keep seniors in independence in their own homes.

Supporting Paper No. 1—"The Litany of Nursing Home Abuses"

This report attempts to summarize the kinds of nursing home abuses, to document which of them occur most frequently and to quantify these abuses. The report concluded that 50 percent of the nursing homes in the United States are substandard.

Supporting Paper No. 2—"Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks"

The report notes that the average nursing home patient may take as many as seven different drugs a day, some of them taken two and three times a day. Nursing home drugs may account for 10 percent of total nursing home expenditures. Almost 40 percent of these drugs are central nervous system drugs including tranquilizers and sedatives.

The report concludes that 20 to 40 percent of the drugs dispensed in nursing homes are given in error and that adverse reactions are common because of poor drug supervision.

Supporting Paper No. 3—"Doctors in Nursing Homes: The Shunned Responsibility"

Physicians have, to a large degree, abdicated their responsibility for personal attention to nursing home patients. One of the reasons for their lack of concern is inadequate training at schools of medicine. Another is the negative attitude toward care of the chronically ill in this Nation. The subcommittee's May 1974 questionnaire to the 101 U.S. schools of medicine indicates a serious lack of emphasis on geriatrics and long-term care:

Eighty-seven percent of the schools indicated that geriatrics was not now a specialty and that they were not contemplating making it one; 74 percent of the schools had no program by which students, interns, or residents could fulfill requirements by working in nursing homes; and 53 percent stated they had no contact at all with the elderly in nursing homes.

Supporting Paper No. 4—"Nurses in Nursing Homes: The Heavy Burden (The Reliance on Untrained and Unlicensed Personnel)"

Of the 815,000 registered nurses in this Nation, only 65,235 are found in nursing homes, and much of their time is devoted to administrative duties. From 80 to 90 percent of the care is provided by over 215,000 aides and orderlies, some few of them well trained, but most literally hired off the streets. Most are grossly overworked and paid at or near the minimum wage. With such working conditions, it is understandable that their turnover is 75 percent a year.

One reason for the small number of registered nurses in nursing homes is that present staffing standards are unrealistic. The present Federal standard calls for only one registered nurse in charge on the day shift, regardless of the size of the nursing home. By comparison, Connecticut requires one registered nurse for each 30 patients on the day shift, one for every 45 in the afternoon; and one for each 60 in the evening.

Supporting Paper No. 5—"The Continuing Chronicle of Nursing Home Fires"

In 1973, there were 6,400 nursing home fires (17.5 each day of the year) causing $3.6 million in damage. An estimated 500 persons lost their lives in single death fires. Fifty-one persons lost their lives in multiple death fires (those killing three or more). These figures represent sharp increases from 1971 when there were 4,800 fires and 31 people killed in multiple death fires.

Nursing home patients are especially vulnerable to fires. Many are under sedation or bound with restraints. Physical infirmities and confusion often cause resistance to rescue.

There is reason to believe the number of nursing homes failing to meet fire safety standards is actually increasing.

In 1971, the General Accounting Office reported that 50 percent of U.S. nursing homes were deficient in regard to fire safety. A January 1974 study by the U.S. Office on Nursing Home Affairs said that 59 percent of skilled nursing facilities are certified with deficiencies. HEW spokesmen indicated that in excess of 60 percent of intermediate facilities do not comply with existing standards. The requirements are on the books, but they are not heeded. Even more dramatically, the GAO 1974 study indicates 72 percent of U.S. nursing homes have one or more major fire deficiencies.

SUPPORTING PAPER NO. 6—"WHAT CAN BE DONE IN NURSING HOMES: POSITIVE ASPECTS IN LONG-TERM CARE"

It is unjust to condemn the entire nursing home industry. There are many fine homes in America. A growing number of administrators are insisting upon positive approaches to therapy and rehabilitation, innovations in physical structure of the physical plant; employee sensitivity training and cooperative agreements with local schools of nursing; and even self-government and other activities for the patients.

"Ombudsmen" programs, first established by Presidential direction, are being established in every State. In some States, the nursing home industry has launched an effort to upgrade its facilities by establishing directories, rating systems, and a "peer review" mechanism. These efforts offer the prospect of improving nursing home conditions if conducted in a vigorous and effective manner. In Chicago, nursing homes have a "cool line" telephone number for relatives, visitors, or patients who have complaints.

SUPPORTING PAPER NO. 7—"THE ROLE OF NURSING HOMES IN CARING FOR DISCHARGED MENTAL PATIENTS"

Thousands of elderly patients have been transferred from State mental institutions to nursing homes. The number of aged in State mental hospitals decreased 40 percent between 1969 and 1974, according to subcommittee data, dropping from 133,264 to 59,685. This trend is caused partially by progressive thinking intended to reduce patient populations in large impersonal institutions. Another powerful reason, however, may be cost and the desire to substitute Federal for State dollars. It costs the States an average of $1,000 per patient per month to care for mental patients in State hospitals while these same individuals can be placed in boarding homes at substantially reduced cost. Charges of "wholesale dumping" of patients have been made in several States. Acute problems have been reported, most notably in California, Illinois, and New York.

Two more supporting papers will be issued in the near future as summarized below. They will be followed by a volume of comments and reactions to the subcommittee's study from interested consumer groups administration spokesmen and provider representatives. To complete the series the committee will release its final report to the Congress with legislative recommendations.

Summary of reports to be issued:

Supporting Paper No. 8—"Access to Nursing Homes by U.S. Minorities"

Only 4 percent of the 1 million nursing home patients in the United States are members of minority groups, even though their health needs are proportionately greater. Part of the problem is caused by cost obstacles or lack of information about medicaid. Discrimination is the greatest obstacle to greater utilization by blacks. But discrimination need not be overt; often relatives are made to feel that their parent or grandparent would not be made comfortable. In the case of Asian-Americans and Spanish-speaking Americans, language barriers often cause insurmountable difficulties. Cultural and other problems, including rural isolation, cause problems to American Indians.

Supporting Paper No. 9—"Profits and the Nursing Home: Incentives in Favor of Poor Care"

Profits by nursing homes have occasioned serious and persistent controversy. Nursing home administrators say that medicaid reimbursement rates are low and that they can hardly become the basis for profiteering. Critics say that the economics of nursing home operation, supported in such large measure by public funds, should be examined more closely and publicly than they now are.

A subcommittee survey made in 1973–74, indicates that the 106 publicly held corporations controlled 18 percent of the industry's beds and accounted for one-third of the industry's $3.2 billion in revenue (as of 1972). Between 1969 and 1972 these corporations experienced the following growth:

—122.6 percent in total assets;
—149.5 percent in gross revenues; and
—116 percent in average net income.

One recent HEW study, however, shows marginal rates of return in a sample of 228 nursing homes. Thus, the issue is far from settled. But a joint study—conducted by the General Accounting Office and the subcommittee—suggest significant increases in revenues, and profits for individual operators as well.

III. PROGRESS TOWARD IMPLEMENTING THE RECOMMENDATIONS OF THE SUBCOMMITTEE'S REPORTS

The subcommittee's reports can be organized under seven topics which Senator Moss described as "the root cause of nursing home abuse." Among these are: The lack of a policy with respect to long-term care, the abdication of the physician, the reliance on untrained personnel, the lax enforcement of standards, and the existence of financial incentives in favor of poor care. Over the past year there was some progress in implementing the recommendations of the subcommittee. Some legislation introduced by Senator Moss in these areas was enacted. In other cases HEW has taken administrative action. It is clear that much remains to be done.

A. Lack of a Policy With Respect to Long-Term Care

In order to help fashion a national policy with respect to the infirm elderly Senator Moss introduced a series of bills designed to expand long-term care.

Among the bills he offered include proposals to:

—Broaden the scope of medicare to provide comprehensive nursing home benefits to all needy Americans without reference to prior hospitalization or ability to pay.

—Broaden the scope of medicare to provide greater availability of in-home services and to authorize the payment for adult day care.

—Amend the Internal Revenue Code to allow a family to deduct as a "medical expense" payments made by a family for the nursing care received by a relative (whether the relative qualifies as a dependent or not).

—Authorize an experimental program to subsidize families to care for their elderly in their own homes.

All of these proposals were opposed by the administration.[1] The administration's only efforts to make home health care more generally available consisted of: (a) offering August 21, 1975, regulations mandating the participation of for profit home health agencies in medicaid and (b) in implementing section 228 of Public Law 92–603 which required the Secretary of HEW to establish presumptive periods of coverage for home health beneficiaries with various medical problems. Because of the intervention of Congress, the August regulations, insofar as they require the participation of for profit agencies in medicaid were rescinded. HEW also opposed funding for the so-called Church amendment to Public Law 94–63 which authorizes Federal funds to help establish home health agencies in rural areas or areas of greatest need. A proposed rescission was rejected by the Congress and only then did HEW spend the $3 million authorized for this purpose.

Public Law 92–603 also required HEW to conduct various demonstration projects with day care and homemaker services. The projects have been completed but HEW has yet to produce a report on the effectiveness of the experiments. The Department has indicated it has no plans to continue the programs.

B. Financial Incentives in Favor of Poor Care

Some 80 percent of America's 23,000 nursing homes operate for a profit. However, the structure of medicare and medicaid reimbursement formulas can encourage them to cheat. Under a flat rate, $20 or $25 a day, operators may decide that the only way to make a profit is to cut back on food or nursing. In a cost-plus system, they could conclude the object is to run up costs which are reimbursable so large salaries are paid, relatives are put on the payroll, and inflated rents are paid to related corporations. This system also can encourage trading in real estate: selling nursing homes back and forth since operators are reimbursed on equity which in turn is determined by the selling price of a home.

In both systems there is a fundamental contradiction between the patient's prime interest (returning home) and that of the operator who needs to keep his beds filled. Under both systems bed-bound patients bring a higher rate of reimbursement than patients who are ambulatory: there is little incentive to rehabilitate patients.

[1] HEW's positions of various issues quoted throughout are taken from the Dec. 17, 1976, letter and detailed enclosures to Senator Frank E. Moss in answer to his letter of Oct. 26, 1976.

Recent rules promulgated in the Federal Register of July 1, 1976, require that the States reimburse their medicaid-participating nursing homes on a cost-related basis. The regulations make no attempt to tie reimbursement to the quality of services offered by the facility. However, the Department has recognized the importance of nursing home performance and outcome measures as evidenced by its patient assessment and care evaluation program (PACE). The program is in its initial phases and is being tested in several States. Implementation of this program into the inspection/certification or reimbursement process is still in the distant future.

C. Increasing Physician Training

Several bills have been introduced in the last session of the Congress which are aimed at sensitizing physicians to the needs of nursing home patients and toward providing greater attention to geriatrics in schools of medicine. These proposals would make Federal funds available to:

—Establish departments of geriatrics in schools of medicine.
—Establish continuing education programs in geriatrics and gerontology.
—Train medical corpsmen discharged from the armed services and physician assistants in geriatrics and the needs of nursing home patients.

HEW opposed the enactment of these proposed bills. HEW spokesmen, however, have been quick to point out that they yielded to congressional pressure and promulgated regulations requiring all skilled nursing facilities (SNF's) participating in medicare or medicaid to hire physicians who agree to serve as medical directors. The proposed regulations were issued in October 3, 1974. HEW spokesmen have said they are convinced the regulations are being aggressively enforced. Patient advocates charge that the regulations are not being enforced, adding that even if they are, that additional efforts are necessary to increase the attention the medical profession pays to nursing home patients.

D. Training for Nurses and Other Personnel

Legislation has been introduced by Senator Moss and Charles H. Percy which would increase the amount of Federal funds available for training nursing home personnel. These proposals include bills to:

—Establish graduate programs for nurses in geriatrics and gerontology.
—Institute continuing education programs for nurses in geriatrics.
—Place increased emphasis on the training of nurse practitioners in geriatrics in order that they may provide primary care in nursing homes.
—Provide expanded in-service training programs for the training of nursing home personnel.

The administration opposed these bills. However, the last two were added as amendments to the Nurse Training Act (Public Law 94–63) by Senator Moss. HEW commented that the enactment of these provisions received wide publicity and that many telephone calls and inquiries and letters of inquiry have been received. In fact, four grant

applications had been received by HEW as of December 1976 but none have been awarded. HEW expects to issue some grants for the training of nursing home personnel in fiscal 1977 according to communications received by the committee.

E. Proposals to Help Nursing Homes Upgrade

Many nursing homes cannot obtain financing needed to secure improvements or renovations. In other cases, church groups and nonprofit agencies have been unable to obtain financing to build nursing homes in areas of great need. Three proposals were suggested including bills:

—Authorizing direct loans for the construction and rehabilitation of nursing homes owned and operated by churches or other nonprofit agencies. Loans would be obtained from the Government at a moderate interest and repayable over a long term.

—Authorizing grants for the planning, development, construction, and rehabilitation of nursing homes in black or minority communities.

—Authorizing the liberalization of FHA section 232 which provides FHA insurance to aid in the construction of nursing homes.

These bills were opposed by the Ford administration.

F. New Standards Needed

In October 1973, the Subcommittee on Long-Term Care conducted hearings relating to the proposed unification of medicare and medicaid standards by HEW. Spokesmen at the hearings indicated that the existing regulations had been "watered down" in the consolidation. Senator Moss introduced several bills designed to restore what had been lost but these bills, for the most part, have been opposed by HEW.

The legislation would have:

—Required physician visits at least once every 30 days. Present rules allow 60-day intervals, or longer in the case of intermediate care facilities, between visits.

—Required skilled nursing homes participating in medicare and medicaid to have at least one RN on duty 24 hours a day, 7 days a week.

—Required that only RN's be permitted to set up and pass medications in skilled nursing homes. As indicated, there is often a significant problem with the poor administration of drugs in nursing homes; average drugs administered in error drop dramatically with the number of RN's on duty.

—Require HEW to promulgate minimum ratios between nursing personnel and patients. Each patient should receive no less than 2.25 hours of nursing time per day. This was an existing Federal standard deleted in 1974. Under present Federal rules, all that is required in nursing homes, no matter what their size, is one RN 7 days a week on the morning shift and one LPN on each of the afternoon and evening shifts.

With respect to physician coverage, HEW has argued that the provision for medical direction will afford patients adequate medical attention. They have opposed the 24-hour-day registered nurse coverage because of (*a*) what they claim is inadequate supply of RN's in the

Nation, and (b) because of possible cost increases which would result with "no corresponding benefit in terms of patient care." Spokesmen for the elderly and groups such as the American Nurses Association have disagreed with both premises.

HEW has used the same arguments to oppose the promulgation of ratios between the nurses and patients and between supervisory nurses and nursing personnel, i.e., the assertion that an increased number of nurses per patient will not necessarily result in better patient care. Studies received by the subcommittee support just the opposite conclusion. For example, one study of nursing home drug distribution proved that the number of drugs administered in error decreased proportionately with the number of professional nurses on the staff. HEW seems to concede this point by new proposed regulations which they claim will limit the distribution of pharmaceuticals to licensed personnel.

G. The Need for Increased Enforcement of Standards

One of the primary conclusions of the subcommittee's reports is the failure of the Department and the States to enforce existing nursing home standards. As of December 1976, HEW officials reported that they had made substantial progress in this regard. As one indication they reported that only 47 percent of medicaid participating skilled nursing facilities were certified with fire safety deficiencies as opposed to 57 percent in January 1974. However, they reported that 79 percent of their sample of the ICF's sampled in 1976 were certified with fire safety deficiencies. While this record indicates improvement, it also illustrates how much there is still left to be done. Legislation was introduced which would:

—Provide strict new controls on the handling of patients' funds.
—Require HEW to establish a rating system for nursing homes as a guide to consumers.
—Require that State inspectors who conduct Federal medicare and medicaid inspections have minimum qualifications and training.
—Require unannounced inspections of nursing homes at least once every 90 days.
—Clarify conditions under which Federal funds can be withheld and medicaid/medicare certification revoked from individual nursing homes.
—Provide 100 percent funding to the States to underwrite the cost of medicare/medicaid nursing-home audits.
—Outlaw the practice of requiring patients to make a gift or other payment to the facility as a precondition of admitting them as medicare or medicaid patients.
—Provide warnings on medicaid forms, that fraud or misstatements of a material fact in conjunction with the program is a Federal crime.
—Create a cadre of Federal inspectors to conduct spot checks of medicare and medicaid facilities to test the quality of State inspection.
—Authorize medicare/medicaid patients (or their guardians) to bring class actions against nursing homes which do not meet standards, offer poor care or endanger the lives of residents.

With respect to controls on patients funds, HEW noted in its December 1976 response that it was circulating a proposed amendment which (when promulgated) would provide greater protection. An audit of the General Accounting Office prepared for Senator Frank E. Moss in March 1976, indicated substantial problems in each of the 30 nursing homes GAO surveyed in 5 States with respect to such funds.

In June of 1974, HEW announced its intention to establish a rating system as a guide to consumers. By December of 1976, HEW was still responding that completion of this goal was a long way off.

With respect to inspectors, HEW maintains that State inspections are, by and large well qualified, even though HEW admits that State surveyors tend to apply Federal standards more "softly" than Federal authorities would like. GAO reported significant problems in its 1975 audit. For example, GAO found only 22 percent of State surveyors who conducted fire inspections in its 11-State sample had the qualifications to do so.

HEW reports that as of 1975, it adopted a policy requiring State surveyors to conduct unannounced inspections but it disagrees as to the necessity of quarterly inspections as conducted by some States. HEW reports issuing Federal regulations to clarify conditions under which Federal funds could be withheld and reported that present regulations forbid nursing homes from requiring patients or families to supplement medicaid payments to nursing operators.

They opposed the remaining three bills without comment.

On the positive side, HEW should be credited with a stout defense of regulations in implementation of the so-called Kennedy amendment of 1967 which required the licensure of nursing home administrators by the States. The regulations correctly stated that State licensure boards set up as in compliance with Federal regulations could not be dominated by nursing home interests. This provision was challenged in court by nursing home operators and their professional associations. The Federal court sustained the HEW regulations.

Beginning in April of 1975, HEW sent notices to the 20 or more States which had boards dominated by nursing home professionals. As of January 1977, all States had reconstituted their boards in conformity with Federal law and regulations.

SUMMARY

It is apparent that there were differences of opinion between the Committee on Aging and the Ford administration on the question of long-term care. The foregoing paragraphs set forth these points in sharp detail. This discussion also provides the committee's view of a rough outline for a national policy with respect to long-term care. This outline is offered not as a fixed conclusion of what must be done; rather, it is presented for comment and discussion by interested parties who are invited to present their views for publication in the committees forthcoming volume. It is clear that there is a tremendous need for action in the area of long-term care. The Nation's elderly have served notice that the time for reform has arrived.

CHAPTER IV

HOUSING: THE DESPERATION LEVEL RISES

Major legislative breakthroughs in housing construction programs for the elderly occurred during 1976, but for many older Americans the high cost of shelter is still a major cause of despair.

Elderly renters continue to pay, on the average, 35 percent of their income for housing. Among renters age 75 and older this figure becomes an astounding 48 percent.[1]

Elderly homeowners (and according to the 1970 census, 68 percent of households with an elderly head own their own homes) have a separate set of problems: Increasing property taxes, high utility costs, and maintenance costs. While the typical urban household spends 3.4 percent of its income for property taxes, elderly homeowners on the average spend 8.1 percent.[2]

Further, close to 5 million homes owned by the elderly are more than 37 years old, and most likely in need of repairs.[3] In addition, skyrocketing fuel and electrical costs have made utility bills a burden to low-income homeowners; many of whom have undoubtedly been forced to leave their dwellings because of high upkeep costs. (See chapter XI, section III of this report for further information on utility costs.)

The housing situation—which was acute at the time of the White House Conference on Aging in 1971—has now become critical. Three years of a housing moratorium—coupled with rampant inflation—have made decent, safe, sanitary housing at manageable rental costs unavailable to a growing number of elderly persons in this country. Moreover, even housing that is decent and affordable may lack the essential services needed for semi-independent living.

Senator Harrison Williams, chairman of this committee's Subcommittee on Housing for the Elderly, recently expressed his rising concern when he said [4] that a housing crisis, "probably of unparalleled magnitude, now grips the older persons of this nation."

He added:

> *The elderly face a situation which in many ways threatens to cripple their economic and emotional well-being in much the same way that the health care crisis threatened them until we solved that problem in part with medicare.*

No single solution by any one level of government will suffice. What is needed now—in varying proportions in different parts of the

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[1] "The Impact of Federal Housing Programs on the Elderly," Congressional Research Service, Library of Congress, Aug. 19, 1976, p. 10.
[2] Page 9 of reference cited in footnote 1.
[3] Page 9 of reference cited in footnote 1.
[4] In a speech at a conference on "Older Persons: Unused Resources for Unmet Needs," City University of New York, Jan. 24, 1977.

Nation—is a combination of workable programs directed at providing construction, rental assistance, home repair, property tax and utility relief, and supportive services.

I. HOUSING—THE HEAVY BURDEN

A new joint study by the Census Bureau and the Department of Housing and Urban Development indicates that rent is nearly three times more of a burden for low-income families than for more affluent families. Persons with incomes under $5,000 (about one-third of all renters) paid 35 percent or more of their income in rent with a median monthly rent of $98. By contrast, renters with incomes of $15,000 or more (about one-seventh of renters) paid a median monthly rent of $180, representing only 12 percent of their total income. The average renter paid approximately 22 percent.[5]

Property taxes—which have jumped by 47 percent in the past 5 years—are a burden to elderly homeowners.[6] As noted earlier, elderly homeowners pay approximately 8.1 percent of their income for property taxes; however, it has been estimated that property taxes account for at least 15.8 percent of the incomes of elderly persons with total incomes less than $2,000.[7] (Since these figures are based on 1970 census data—and do not reflect the high inflation of the seventies—they may be low estimates.)

In one extreme instance reported to the committee, an elderly widow with an annual income of $1,176 paid $796 for property taxes, or almost 70 percent of her poverty income.[8]

Varying versions of property tax relief programs have been enacted by all 50 States and the District of Columbia, 2 States abandoned these programs during 1974.[9]

According to research[10] prepared for HUD:

> At the close of 1974, 48 States and the District of Columbia had authorized 83 different programs. The circuit breaker program type[11] disbursed nearly $500 million in benefits to 3.2 million claimants of all ages in 1974, with an average relief payment of $143. Homestead exemptions,[12] the other major program type, distributed in 1973 more than $1 billion in benefits to at least 6.3 million claimants of all ages, the average benefit standing at $173. The elderly received preferential treatment in all but three of the programs surveyed.

The following map shows, on a State-by-State basis, the type of programs that have been enacted:

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[5] Annual Housing Survey: 1974, U.S. Department of Commerce and U.S. Department of Housing and Urban Development, September 1976.

[6] Statement by Senator Harrison Williams, Congressional Record, Nov. 10, 1975, p. S 19508.

[7] Financing Schools and Property Tax Relief, Advisory Commission on Intergovernmental Relations, pp. 13 and 38, 1973.

[8] Reference cited in footnote 6.

[9] Property Tax Relief Programs for the Elderly: A Compendium Report, prepared for HUD by Abt Associates, Inc., Cambridge, Mass., Apr. 1975, p. ii.

[10] Property Tax Relief Programs for the Elderly: Final report, prepared for HUD by Abt Associates, Inc., Cambridge, Mass., November 1975, p. 3.

[11] Circuit breaker: Programs function like a negative income tax mechanism applied to property tax liability. They ease the tax liability relative to income, the portion of tax relieved increasing as income falls. The income of the claimant is used determining both eligibility and the amount of relief each household will receive. [Report cited in footnote 9.]

[12] Homestead exemption: Programs operate like a direct grant, reducing the assessed value of homes of all persons who are eligible, by the same amount. Although income may be a criterion of eligibility for homestead exemption relief, it is not actually used to determine the amount of relief the claimant will receive. [Report cited in footnote 9.]

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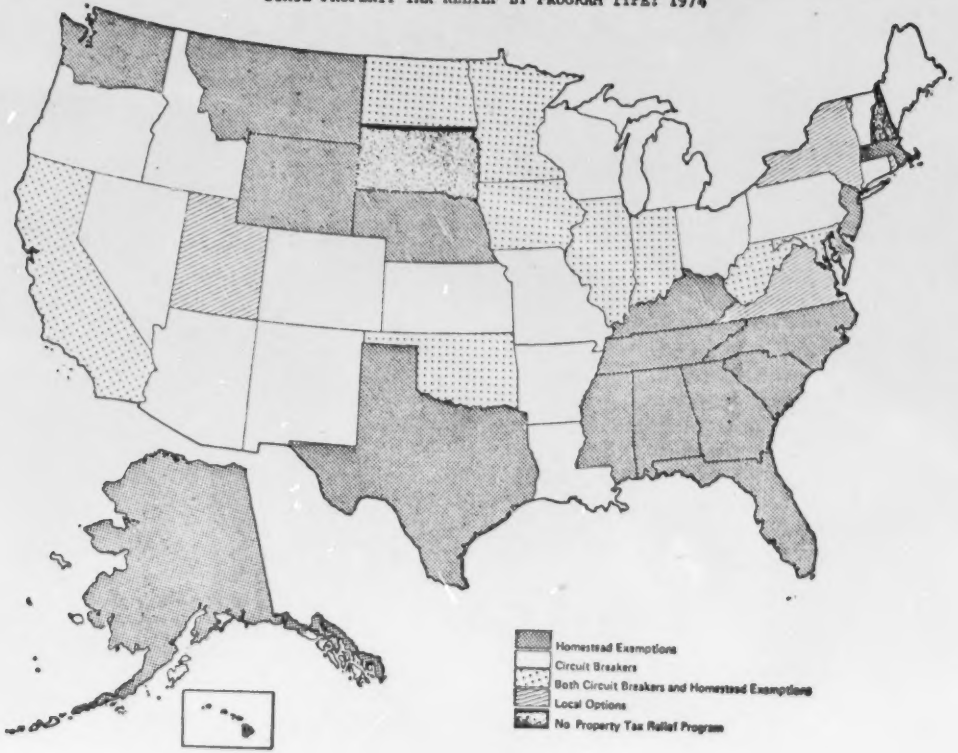
STATE PROPERTY TAX RELIEF BY PROGRAM TYPE: 1974



It cannot be assumed, however, that the enactment of property tax relief automatically reduces the taxes that an elderly person pays.[13]

Other Forms of Help

State and local governments are taking other actions to help older persons cope with the cost of shelter. For instance:

—In Seattle, Wash., the electric company provides free repairs and parts for major and necessary appliances to low-income elderly persons along with significant utility rate reductions, and reduced water and sewer charges; [14]

—In Jersey City, N.J., a program for the low-income elderly includes home repair and winterization, cash assistance to persons whose utilities are about to be terminated, and a communitywide training program on home repair techniques; [15]

—In Clearwater, Fla., a rehabilitation loan program financed by city revenue sharing and community development moneys enables older persons who cannot afford loan payments to receive an advance to cover rehabilitation costs up to a maximum of $5,000. The amount advanced to the homeowner is expected to be repaid when the property is sold or transferred to another person. For other low-income homeowners, low-interest-rate loans are also available from this fund.[16]

II. THE LIMITED FEDERAL SPECTRUM

> "The key to new [housing] programs must be options and alternatives. Flexibility must be encouraged; local initiative rewarded. We have the opportunity today to shape the housing programs we need for a new era in response to our aging population and their widely varying needs."
>
> —Harrison Williams [17]

Once again in 1976, the direct loan 202 program received major congressional attention. But even the architects and supporters of that program are among the first to declare the need for additional efforts.

A. Section 202: Closer to Reality

The signing of the fiscal year 1977 HUD appropriations bill (P.L. 94–378) on August 9, 1976, culminated the efforts of the past 2 years in renewing the section 202 program. (See earlier editions, Developments in Aging.) This bill made $750 million in loan authority available for the popular 202 program which is utilized by nonprofit sponsors to develop housing specially designed for the elderly and handi-

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[13] According to an article in the Washington Post (Sept. 20, 1975), a Maryland couple's property taxes rose $65 after the State legislature enacted a "circuit breaker" property tax relief measure. Although the State legislature had provided for a credit on the State level, it nullified other laws under which 9 counties had frozen either the assessments or the actual tax payments of senior citizens.

[14] "Serving the Urban Elderly: Strategies for Mayors," U.S. Conference on Mayors Task Force on Aging, August 1976, p. 34.

[15] Page 35 of reference cited in footnote 14.

[16] Page 59 of reference cited in footnote 14.

[17] Speech entitled "The Future of Section 202," delivered before the Elderly Housing Practitioners Workshop, Feb. 27, 1976.

capped. A similar level of funding was available in fiscal year 1976 for this program which had not been funded since the late sixties.

Another major victory was achieved just prior to the appropriations enactment when the Housing Act of 1976 was signed. This measure—Public Law 94-375 (Aug. 3, 1976)—made significant changes in the 202 program.

First, it incorporated a provision offered by Senator Williams which increased the overall borrowing capacity of the section 202 program by $2.5 billion to a total of $3.3 billion, a level of funding which, according to Senator Williams, is "essential if we are ever to put 202 on a realistic, pay-as-you-go basis which can become a cornerstone of a national effort to provide decent housing for older Americans." [18]

Second, the interest rate computation method for 202 sponsors was revised to reflect more clearly the actual cost to the government of making these loans. Senator Proxmire, chairman of the Senate Banking, Housing, and Urban Affairs Committee, charged that under the present formula HUD was making a profit off the elderly by borrowing at a short-term rate of about 6.5 percent and then lending this same money to 202 sponsors at 8¼ percent.[19]

Third, HUD was directed to use actual development cost (rather than the average cost of all comparable buildings, old or new, in the area, as is now the case) in determining the section 8 [20] contract rents for 202 projects. As a result, 202 projects will not continue to be handicapped by the low-contract rents set by the administration under the section 8 program which are more appropriate for existing housing than new construction.

Fourth, the act provided that Federal housing assistance would not be counted as income for the purpose of determining eligibility for SSI.

With these changes, the 202 program—revised and rejuvenated by the Congress in 1974—stands now to be an even more effective program than it was in the sixties.

Unfortunately, the time lapse between project approval and the actual ribbon cutting ceremonies is lengthy. The first new 202 units will, however, be occupied by the elderly in 1977.

B. Public Housing—Will it Serve the Elderly?

Public housing also found new life in 1976 when the Congress mandated that HUD use at least $85 million of the public housing construction funds for new construction (Public Law 94-378, August 9, 1976). The administration—which had been using the funds allotted under the Housing Act of 1974 (Public Law 93-383) for acquiring defaulting properties instead of new construction—finally announced in November 1976 that the congressional mandate would be carried out. Approximately 14,000 new or substantially rehabilitated public housing units are to be constructed, 10,000 existing apartments acquired, and 6,000 units of subsidized housing for American Indians provided under the congressionally revived program.[21]

[18] Congressional Record, Apr. 27, 1976, p. S. 6035.
[19] Mark-up session on S. 3295, March 1976.
[20] For additional discussion of section 8, see below.
[21] HUD press release, Nov. 19, 1976.

However, opposition to the proposed regulations accompanying this "mandate" cropped up immediately.

One of the points of opposition is the virtual exclusion under the regulations for the development of units for the elderly. The proposed rules call for projects designed for households whose needs are not "being met proportionately to their share of total housing needs . . . as shown by the approved housing assistance plan or HAP's applicable to the jurisdiction" of the Public Housing Authority.[22]

They further state that it is intended that projects under these regulations provide primarily scattered site or otherwise low-density housing for families, including large families with children, since the housing needs of such families are not adequately served by other housing programs.[23]

As a result, housing units for the elderly are an extremely low priority item in a limited-budget program.

C. Section 8: Still Under Fire

The section 8 program—initiated by the administration in 1974 to provide rent supplements to low-income persons [24]—has yet to meet its mark. Initially the administration had indicated that the section 8 rental assistance program would benefit 400,000 households in fiscal year 1976, an estimate that was later revised to only 200,000 households.

As of November 1976, only 76,896 households were placed in existing housing, while 4,097 were actually occupying newly constructed units under the section 8 program, and 595 households were occupying substantially rehabilitated units.

Although the program has been slow getting off the ground, the elderly have fared well in the tenant selection process. HUD estimates that approximately 44 percent of section 8 participants are elderly persons.

COMPLAINTS ABOUT COSTS

The section 8 program has been attacked as the most costly of the housing subsidy programs.

A study conducted by the Library of Congress and released in May 1976 indicated that public housing was the least expensive approach to housing low-income persons with an annual subsidy per unit of $3,524. Section 8 financed through a State housing finance agency was the most expensive with a subsidy of $4,015, while section 8 financed with an FHA insured loan cost $3,643 per unit per year and section 236 with rent supplement averaged $3,580.[25] HUD countered with their own analysis, arguing that section 8 costs are $26 per unit

[22] Federal Register, Nov. 18, 1976, p. 50946.
[23] Reference cited in footnote 22.
[24] Under section 8 of the Housing Act of 1974, HUD can provide housing assistance payments to families with incomes not exceeding 80 percent of median income of their localities in newly built, extensively rehabilitated, or existing housing. Very low income tenants generally pay no more than 15 percent of their incomes for rent; higher income tenants pay no more than 25 percent. The Secretary is required to take into consideration the income of the family, the number of minor children in the household, and the extent of medical or other unusual expenses incurred by the family in determining these payments.
[25] "Comparative Costs of Housing for Low-Income Families Under Several Federally Assisted Programs," prepared by Morton Schussheim, Library of Congress, May 27, 1976.

per year less than conventional public housing, based on different data or usage of data.[26]

However, the HUD analysis was challenged when the General Accounting Office released a report on July 28, 1976, entitled "Comparative Analysis of Subsidized Housing Costs." This report—which analyzed the long-term costs of the programs—indicated that for a low-income tenant, public housing is the least costly method, with section 8 being somewhat less expensive than section 236 with rent supplements.

GAO estimates that the direct subsidy under section 8 will probably be uniformly higher at all incomes than the two programs that it was intended to replace—section 236 and public housing.[27]

D. HUD Reorganization

Advocates of the establishment of an Assistant Secretary for Housing for the Elderly were dealt a blow in the spring of 1976 when HUD transferred the Office of the Assistant to the Secretary for Programs for the Elderly and Handicapped to the Office of Consumer Affairs and Regulatory Functions. The title "Assistant to the Secretary" was changed to "Departmental Advisor"; and this person reports to the Assistant Secretary for Consumer Affairs, instead of directly to the Secretary.

As early as 1971, Senator Williams had proposed an Assistant Secretary for Housing for the elderly who would "administer and coordinate housing programs for older Americans . . . [and] serve as a clearinghouse of information concerning housing for aged persons."[28]

In 1972, this request was partially granted through the establishment of an Assistant to the Secretary for Housing for the Elderly and Handicapped with direct reporting responsibility to the Secretary. The recent change undermines this reporting responsibility, and Senator Williams expressed his concern to then-Secretary Carla Hills regarding "any realinement at HUD which may further erode attention paid to housing for the elderly."[29]

The Ad Hoc Coalition of Housing for the Elderly—composed of such organizations as the American Association of Homes for the Aging, National Council of Senior Citizens, American Association of Retired Persons, and the International Center for Social Gerontology—has also expressed dismay at the departmental action, and has agreed to make the establishment of the position of an Assistant Secretary for Housing for the Elderly one of their early goals for 1977.[30]

E. Limitations in Supportive Services

In last year's annual report, this committee described the need for social services integrated into housing to help elderly persons remain independent or semi-independent and avoid unnecessary institutionalization.

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[26] Housing Affairs letter, June 25, 1976, p. 3.
[27] "Comparative Analysis of Subsidized Housing Costs," p. 14.
[28] Introduction of S. 1935, Congressional Record, May 24, 1971, p. S 7637.
[29] Letter from Senator Williams to Carla Hills, July 26, 1976.
[30] Discussion of Ad Hoc Coalition of Housing for the Elderly, Sept. 17, 1976.

It was revealed that an estimated 3 million older persons need assistance with their daily living activities and, of these, 2.4 million are potential candidates for congregate living—a living situation which embodies not only housing units but essential service components as well.

The major barriers to providing this type of housing were described by former U.S. Public Housing Commissioner Marie McGuire Thompson as (1) the gap between the cost of food and other services and the paying ability of low-income persons, (2) unfamiliarity with tenant selection policy, and (3) the lack of resources available to housing authorities to provide necessary service programs.

HUD CONGREGATE STUDY

Research prepared for HUD and released in September indicates that existing congregate housing is primarily available to elderly persons with higher mean incomes than the U.S. elderly population at large, as the combined housing and services package is clearly more costly than conventional housing.[31]

The study responds favorably to congregate housing as a necessary option in the housing spectrum, and reveals that "congregate housing facilities perceive themselves as being in the business of providing not just housing, or even housing plus meals, but housing and a broad array of supplementary services." Further, the "most prevalent service types appear to be those which stress physical activity and independence." [32]

All of the elderly respondents in the study had chosen to live in a congregate setting even though 85 percent of them came from independent settings.

"In opting for the congregate package, they are opting for the security of knowing they can depend on on-site services and that they will be cared for when they need the care," [33] said the report.

NAHRO'S RECOMMENDATIONS

At its annual convention in New Orleans, La., in October 1976, the National Association of Housing and Redevelopment Officials advanced a far-reaching proposal providing for a long-term commitment for supportive services in public housing.

NAHRO calls for the "adoption of a consolidated Federal housing assistance program that responds to the varying needs for housing assistance among low-, moderate-, and middle-income households and that encompasses in a comprehensive package, all the elements necessary to insure long-term success of housing efforts."

Furthermore:

> A program of essential supportive services should be stated at the initiation of each housing development and long-term contracts for these services should be jointly executed between

[31] "Evaluation of the Effectiveness of Congregate Housing for the Elderly," prepared for HUD by Urban Systems Research and Engineering, Inc., Cambridge, Mass., September 1976, p. 9.
[32] Page 4 of reference cited in footnote 31.
[33] Page 10 of reference cited in footnote 31.

the housing sponsor, the local community, the Department of Housing and Urban Development, and the Department of Health, Education, and Welfare or other Federal agencies that can supply funding resources. Such supportive service funds should be made available directly to the housing sponsor, who can perform these services directly or contract with local agencies or individuals to supply them.[34]

STATE AND LOCAL APPROACHES

Among the innovative approaches to congregate living that have come to the attention of this committee are:

(1) The provision of communal living for the elderly by "creative housing for older persons" sponsored by the Richmond Fellowship of America, a nonprofit organization that specializes in making living arrangements for persons with special needs. Under this program small households of from four to six older persons are being set up beginning with two individuals and expanding from there. Each household operates independently with no supervisory or health care personnel located within. The fellowship holds weekly meetings with the residents to discuss problems. Rents begin at $80 per month, and are based on a person's ability to pay. The fellowship has set up three such communal residences in Washington, D.C., and has plans for more.

"This project was really a godsend for me," stated one of the residents. "The building I lived in was finally sold and I feared being sent to a nursing home, cooped up all day with nurses telling me what to do."

The new creative housing project quickly dispelled those fears.[34a]

(2) The renovation of the historic St. Johnsbury House in Vermont into a senior citizens residential and activity center with funds from the Economic Development Administration and the community development block grant program.

In addition to the 42 residential units, commercial space will be rented by a bus company and a beauty shop to help pay costs of management.[35]

(3) Efforts by the State of Delaware to renovate four large residences into grouped housing for persons over 60. Each house will provide a home for 10 to 15 persons who are ambulatory, capable of performing daily tasks and sharing light housekeeping chores. The homes are intended primarily as an economic alternative, not a health one. Each will have a private bedroom with one bath for four persons. They will share living and dining rooms and a large community kitchen. The homes will be located near transportation lines and community facilities.[36]

(4) The conversion of a vacated schoolhouse in the fishing resort of Gloucester, Mass., into attractive, moderately priced rental apartments for the community's older citizens. It is in the heart of the business district; grocery stores, banks, and other commercial establishments are within easy walking distance.

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[34] NAHRO's 1976 policy document.

[34a] Based on personal interview with Richmond Fellowship of America personnel, January 1977 and Washington Post article, Sept. 22, 1976.

[35] "Congregate Housing Examples Sparse: The Older American," August 1976.

[36] Letter in committee files.

Rents average about $200 a month, but residents pay according to their means.

Several nonprofit and State government agencies were involved in the planning and execution of the conversion. Senior Home Care Services, Inc., provided a grant to support the feasibility study and the Massachusetts Housing Finance Agency approved a low-interest loan of $1.8 million.[37]

(5) In Plainfield, N.J., the housing authority makes grants to elderly homeowners so that they can convert a single-family dwelling into a duplex or triplex. The grants are paid back from the rents of the tenants. This program does not provide supplementary services, but it does bring the tenants into existing service systems and provides the elderly homeowner with the security of neighbors.

(6) A joint working agreement between the Alabama Commission on Aging and the Birmingham/HUD area office to further the goal of a comprehensive, coordinated social service delivery system designed to facilitate independent living for Alabama's older population. This agreement reportedly has produced $3 million in benefits to Alabama's elderly, particularly those whose economic status makes it appropriate for them to reside in public housing.

NEED FOR FEDERAL PUSH

Much more could be done, however, with encouragement and support by the Federal Government, such as the development of long-term commitments to provide the supportive services necessary to insure viable congregate housing facilities. In this way, the Federal Government would be giving the same commitment to the success of supportive services that it does to the success of physical structures through 40-year mortgage commitments.

A step toward this linkage between housing and services occurred in July when the Administration on Aging and the Department of Housing and Urban Development entered into the third of their "working agreements" on necessary links between housing and service programs. Earlier agreements focused on coordination of the two agencies on the community development block grant program and the development of nutrition program sites in public housing. The July agreement focuses on the linkage of services provided under titles III and VII of the Older Americans Act and facilities assisted under HUD's section 202/8 program. HUD and AoA will share in the responsibility for insuring that housing projects are informed of potential service programs that may be utilized by their residents, and that service providers will, in turn, be advised of housing proposals and applications for new developments in their vicinity.[38]

F. Management and Training

Final regulations requiring certification of resident managers and assistant resident managers for public housing were issued by HUD on September 29, 1976.

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[37] Reference cited in footnote 35.

[38] See part 2 appendix 3, item 4, AoA report to the Special Committee on Aging, "Joint Working Agreement Between the Administration on Aging of the Department of Health, Education, and Welfare, and the Organization of the Assistant Secretary for Housing—Federal Housing Commissioner of the Department of Housing and Urban Development on Housing and Social Services for the Elderly."

-CC 87

Under the regulations, HUD is establishing a Certification Review Committee to evaluate organizations and programs with certification capability. All managers of projects of 75 or more units must be certified in order for their salaries to be considered operating expenditures in budgets submitted to HUD. Persons now on the job would automatically be certified if they have had at least 4 years of satisfactory on-the-job performance.

HUD has indicated that it will recognize the National Association of Housing and Redevelopment officials and the National Center for Housing Management as certifying agencies in the public housing field, although their approaches to certification differ. NAHRO relies primarily on the results of a written examination, while NCHM offers an actual training program.

As nearly 40 percent of the occupants of public housing are at least 62 years of age (many of them in developments exclusively for the elderly), Senator Williams suggested to Secretary Hills that HUD require separate certification requirements for the managers of housing for the elderly. He stressed the need for knowledge of Federal programs serving the elderly and familiarity with the special characteristics of the aging process in the management of housing for the elderly. However, the final regulations had no special requirements for housing for the elderly.

Certification regulations are also nearing release for the managers of insured and assisted housing such as section 202 and section 8 developments.

EXPERIMENTS IN TENANT MANAGEMENT

Three years ago the Ford Foundation initiated a pilot study in tenant management in St. Louis, Mo. Under tenant management, the tenants gradually assume the responsibility for rent collection, reviewing tenant incomes on which rents are based, screening new tenants, and developing social service programs.

In the five Ford Foundation-funded public housing projects that have come under tenant management, rent collections are up noticeably, vacancies have been reduced over the 3 years by 18 percent, and maintenance backlogs have decreased by 78 percent.

Not only have HUD modernization funds and Ford Foundation moneys figured into the St. Louis operation, but the city government allocated over $1 million of its Federal community development block grant funds for this program.

According to a recent study by the St. Louis University Center for Urban Programs, there has been "a noticeable improvement in tenant morale and sense of community" in the project that is "not easily measurable yet [is] clearly present and palpable." [39]

However, the study further warns that it remains to be seen "whether, or for how long, the tenant manager can escape identification as another bureaucrat acting in spite of rather than on behalf of, the tenant." [40]

As a result of the initial success of the tenant management experiment, the Ford Foundation and HUD announced in July that six

[39] "Experiments Improve Public Housing," Washington Post, July 6, 1976, p. A5.
[40] Reference cited in footnote 39.

cities had been selected to test whether some of the problems in running low-rent public housing can be solved by the people living there. Jersey City, N.J., Louisville, Ky., New Orleans, La., Rochester, N.Y., New Haven, Conn., and Oklahoma City, Okla., will all participate in the $21.4 million experiment.

According to HUD, "If successful in the new cities, the program will be made available to as many as 3 million people in 1.4 million public housing units across the country to improve their living conditions."[41]

Each of the participating housing authorities will begin with the establishment of a tenant management corporation which will assume increasing management responsibility over the course of the demonstration.

The demonstration program has five major objectives: more efficient management, less social delinquency, more job opportunities, heightened community spirit, and an overall sense of involvement for tenants. HUD will fund operating expenses and physical improvements at the sites with $15 million in modernization program funds, plus $5.2 million under its target projects program (TPP). The remaining $600,000 in HUD research funds will aid in supervision and evaluation of the program.

None of the projects involved is exclusively for the elderly; however, it is possible that these concepts could be applied to housing for the elderly at a later date.

III. THE SRO COMMUNITY

In recent years, this committee has become increasingly aware of the problems of elderly persons who reside in single room occupancy hotels, a population which was described at a St. Louis conference as "the least visible of an invisible population."[42]

It has only been in recent years that social scientists and service providers have detected the SRO population within the inner-city hotels. Urban redevelopment efforts of the sixties brought attention to this population, living in single rooms—usually with shared or community bath and no kitchen units. Relocation, when forced upon them, usually meant simply a move to another SRO hotel.

In some localities, local and State governments have attempted to rehabilitate the hotel structures and bring services to tenants. The Federal Government has not, however, responded, even though the SRO problem exists not only in many larger U.S. cities but in smaller municipalities as well.

Because these units are not self-contained (with private baths and kitchen facilities), HUD programs will not fund or insure their rehabilitation and renovation. To rehabilitate these units into self-contained units would result in an estimated loss of 50 percent of the units, and more than double the rental rates per tenant.

Kitchens and private baths are not a requisite of the SRO lifestyle; living in the center city and having low-price meals and accommodations are. Through the selective easement of regulations, the Federal

[41] HUD Press release, June 30, 1976.
[42] Second conference on the SRO elderly, St. Louis, Mo., May 15–16, 1976.

Government could help communities make SRO housing clean, safe and habitable—and preserve a lifestyle that some older Americans prefer.

This committee will publish a working paper in the near future which will discuss the problems of the elderly SRO population as discussed at the second annual conference on the SRO elderly in St. Louis, Mo.

IV. THE RURAL COMMUNITY

Senate Committee on Aging hearings on "The Nation's Rural Elderly" took place in three States during 1976. (See chapter IX for details.)

Not only did elderly persons describe to the committee their difficulties in getting suitable housing—waiting lists for existing senior apartments averaged 2 years—but additional problems of maintenance of homes, insulation and weatherization, and access to services all posed serious threats for continuance of independent living.

Some progress occurred during 1976 on the rural housing front:

—The fiscal year 1977 appropriations bill enacted in July 1976 (Public Law 94–351) contained $300 million for the Farmer's Home Administration 515 program, an increase of more than $50 million. Under the 515 program, FmHA makes direct loans to nonprofit and limited profit sponsors to finance rental or cooperative housing and related facilities for occupancy by low- to moderate-income rural families and senior citizens 62 years or older. Rental and occupancy charges for low-income families are based on family income and cannot exceed 25 percent of income.

—As mentioned earlier, new construction under the public housing program was rejuvenated under legislation enacted in August 1976. At least 15 percent of these funds must be utilized in nonmetropolitan areas.

—The section 202 program was greatly expanded (elsewhere this chapter) and approximately 20 percent of the new proposals were for nonmetropolitan areas.

—The grant section of the FmHA section 504 program was activated through the earmarking of $5 million in the fiscal year 1977 agriculture appropriation bill (Public Law 94–351). In addition, this bill appropriated $15 million for the counterpart low-interest loan program. Under this program, home repair loans (maximum $5,000) bearing a 1 percent interest rate for up to 20 years, are available for very low-income families in rural areas. Under the grant section, actual cash grants are available to needy families. This is of particular significance to the elderly, since past experience with the loan program has indicated that many elderly persons are reluctant to make loan commitments because of advancing years.

—Public Law 94–351 also made $3.196 billion available for the FmHA section 502 program, $2.23 billion of which is earmarked for special low-interest loans for low-income persons. This program may be used to buy, build, improve, or relocate homes and related facilities. It provides 8½ percent interest loans for low- to moderate-income families. Eligible families may receive interest credits which may reduce the effective loan interest rate to 1 percent.

FINDINGS AND RECOMMENDATIONS

Housing continues to remain the No. 1 expenditure for the elderly and accounts for more than one-third of their personal budget expenditures. Further, at least 30 percent of the elderly live in substandard, deteriorating, or dilapidated housing.

Consequently, it must be the combined role of State, local and Federal governments to provide safe, decent, and affordable housing for the Nation's elderly. In addition, this housing must be suitable to accommodate the special characteristics of the aging population.

The committee recommends the following actions in order to accomplish this goal:

- **—Housing construction under the section 202 program be funded at a rate that will produce a minimum of 35,000 units of housing for the elderly annually.**
- **—Regulations be developed for the public housing construction program which do not exclude the construction of units for elderly persons.**
- **—The rental assistant programs take into consideration the special needs of elderly persons.**
- **—The Federal Government assumption of responsibility for long-term service commitments in order to make housing with services a viable and available choice in the housing spectrum.**
- **—Existing home repair and winterization programs to be continued and expanded as needed.**

CHAPTER V

STEPS TOWARD AN AGING NETWORK

Over the past decade, Federal funding for social services for the elderly has increased significantly. Influenced by obvious need, aggressive efforts by the Federal, State, and local levels, new legislative initiatives, and growing demand by the elderly constituency, the availability of services for the older person has increased.

The Older Americans Act illustrates this trend. In 1966, after 1 year of operation, its appropriation was only $6.5 million. This small budget helped support a handful of State agencies on aging and scattered, usually small, programs at the local level. In contrast, for fiscal year 1977 the appropriations are over 50 times that amount—approximately $401 million. These funds will be used to help support State agencies in every State and territory, more than 500 area agencies on aging, 833 nutrition programs for the elderly, almost 1,000 multipurpose senior centers, an array of research and training grants, and approximately 200 model projects or demonstration programs.

The Older Americans Act not only provides a positive picture of growth in numbers and dollars, but acts as a powerful catalyst in influencing other Federal programs to give emphasis to the older American. Varying by State, such Federal programs as title XX, community development block grants, revenue sharing, transportation, Comprehensive Employment and Training Act (CETA), title X of the Public Works and Economic Development Act, sections 8 and 202 housing programs, postsecondary and community education, legal services and tax counseling, home health services, and an array of other services which serve the elderly are growing in scope and availability. (These programs are discussed in detail in other parts of this report.)

The Older Americans Act—under the auspices of the Administration on Aging of the Department of Health, Education, and Welfare—has also influenced private foundations, church affiliated services, volunteer programs, private organizations, and State and local programs to provide or broaden activities related to aging in an effort to develop a comprehensive service system for the elderly.

This comprehensive system is becoming known as the "aging network." [1] The network begins at the Federal level within the Administration on Aging (AoA) and includes State offices on aging, area agencies on aging, nutrition programs, and the emerging mulitpurpose senior centers under title V of the Older Americans Act. This framework provides visibility to service providers and the elderly consumer, as well as a system which is adaptable to the particular service needs of the State or community. The network is uniform in design but diversified in operation, according to the assessed needs and local inclinations within the specific geographic and demographic areas

[1] U.S. Commissioner of Aging Arthur Flemming refers to this "network" often in speeches and directives to State and local units. In this report, "network" refers not only to the Administration on Aging, and State and local agencies which receive much of their funding through the Older Americans Act, but also to official agreements and channels of communications which are developing among agencies on aging and other governmental units—and private organizations which do not necessarily have aging as a prime concern.

which it must serve. The Congress intended that such flexibility be feasible but also that the broad national goals of title III of the Older Americans Act (grants for State and community programs on aging) be carried out. House-Senate conferees, in approving the Older Americans Amendments of 1975 (Public Law 94–135), stated:

> States should have some flexibility in organizing themselves to administer Federal programs in which they elect to participate, including Older Americans Act programs. However, any organizational scheme relative to title III and title VII must conform to the intent and purpose of the Older Americans Act. The Commissioner on Aging should not approve any State plan which does not provide for a single, identifiable focal point on aging.[2]

I. THE OLDER AMERICANS ACT

A. Funding Increases

Funding for the Older Americans Act increased markedly in 1976. Senators Eagleton, Brooke, and Church led Senate efforts for fiscal year 1977 appropriations of $401.6 million for titles under that act. This represented an increase of approximately $133.2 million over the fiscal year 1976 appropriations and more than $209.5 million above the administration's budget request for fiscal year 1977.

The fiscal year 1977 Labor-HEW Appropriations Act became law on September 30, 1976 (Public Law 94–439). This enactment occurred after both Houses of Congress overrode the President's veto of this legislation on September 29. The enacted law included the following for the Older Americans Act:

Funding for fiscal year 1977

(in millions of dollars)

	Appropriation
Title III:	
Social services	$122.0
Model projects	12.0
Administration	17.0
Subtotal	151.0
Title IV:	
Training	14.2
Research	8.5
Gerontological centers	3.8
Subtotal	26.5
Title V: Multipurpose senior centers	20.0
Title VII: Nutrition program	[3] 203.525
Federal Council on Aging	.575
Total	401.6

[2] Conference report, Older Americans Amendments of 1975, Report No. 94–670, Nov. 17, 1975.

[3] Title VII, the nutrition program for the elderly, was supported by an appropriation of $203.525 million and an operating level of $225 million which would be reached by the States using funds carried over from fiscal year 1976.

The House and the Senate were unusually united in their proposed levels of appropriations for fiscal year 1977. A major factor in the House was a statement of support from the House Select Committee on Aging. In addition, the Members of both Houses were firm in their justifications for such increases.

House Members of the Committee on Appropriations recommended large increases "to cover the cost of inflation and to provide expansion of local project coverage. These funds are to be used to support the preparation and carrying out of annual plans by the State and local agencies on aging." [4]

Senate Committee on Appropriations members declared:

> The additional funding is necessary to establish new area agencies on aging and to expand services directed toward helping older persons maintain independent living in their own residences and to continue participating in their community activities. The committee expects that emphasis will be placed on the designated national priority services as provided in the 1975 Older American Act Amendments; namely, transportation, legal, and other counseling and assistance, home services, and residential repair and renovations.[5]

In addition, the Congress also included appropriations for title V of the Older Americans Act, multipurpose senior centers. Enacted in 1973, title V had not been funded until the transitional quarter of fiscal year 1976, when it received $5 million.[6] The Appropriations Committees agreed upon a $20 million appropriation for title V to be allotted to local applicants in every State. (Title V is discussed in greater detail later in this chapter).

B. Program Progress in Title III

In 1976, area agencies on aging were operative in 90 percent of the areas in which the elderly population are concentrated. Area agencies, those bodies at the local or community level which are authorized by the Older Americans Act to be focal points of coordination of services for the elderly, had grown in number to 498 operating agencies throughout the country (536 areas have approved area plans). In addition, 596 planning and service areas covered the entire country will 11 States being designated as single State planning and service areas.[7] By the end of fiscal year 1977, the Administration on Aging estimates that 545 of the 596 planning and service areas will have approved area agencies on aging.

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[4] Report of the House Committee on Appropriations to accompany Departments of Labor, and Health, Education, and Welfare, and related agencies appropriation bill, 1977, H. Rept. 94–1219, June 8, 1976.

[5] Report of the Senate Committee on Appropriations to accompany Department of Labor and Health, Education, and Welfare and related agencies appropriation bill, 1977, S. Rept. 94–997, June 26, 1976.

[6] Beginning in fiscal year 1977, the fiscal year will begin on Oct. 1 instead of July 1. The period between June 30 and Sept. 30, 1976, was known as the transitional quarter for fiscal year 1976.

[7] Under the Older Americans Act, as amended (Public Law 89–73), a planning and service area is any unit of general purpose local government which has a population aged 60 or over of 50,000 or more, or which contain 15 percent or more of the State's population aged 60 or over. Exceptions have been made, such as the entire State being designated as a single State planning and service area and approved by the Commissioner. Currently, Alaska, Nevada, North Dakota, South Dakota, New Hampshire, Delaware, Rhode Island, District of Columbia, Guam, Samoa, and the Virgin Islands are designated as single State Planning and service areas.

AUTHORIZED FUNDING LEVELS FOR FISCAL YEAR 1977 FOR TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED (13.633)

[Available for obligation through Sept. 30, 1977]

States	Population 60 plus, July 1, 1975		Title III	
	Unrounded population	Percent distribution	Area planning and social services [1]	State administration
Total 56 "States"	31,953,950	100.00000	$120,780,000	$17,000,000
Alabama	534,897	1.67396	1,939,191	228,521
Alaska	15,784	.04940	603,900	200,000
Arizona	317,967	.99508	1,152,746	200,000
Arkansas	373,967	1.17033	1,355,763	200,000
California	2,930,960	9.17245	10,625,833	1,252,183
Colorado	302,076	.94535	1,095,136	200,000
Connecticut	462,346	1.44691	1,676,166	200,000
Delaware	72,045	.22547	603,900	200,000
District of Columbia	101,987	.31917	603,900	200,000
Florida	1,781,967	5.57667	6,460,267	761,299
Georgia	618,320	1.93503	2,241,626	264,161
Hawaii	87,768	.27467	603,900	200,000
Idaho	115,304	.36084	603,900	200,000
Illinois	1,643,227	5.14248	5,957,282	702,026
Indiana	746,877	2.33735	2,707,692	319,083
Iowa	493,705	1.54505	1,789,856	210,923
Kansas	385,756	1.20722	1,398,498	200,000
Kentucky	515,411	1.61298	1,868,549	220,196
Louisiana	492,108	1.54005	1,784,064	210,240
Maine	172,919	.54115	626,893	200,000
Maryland	500,390	1.56597	1,814,091	213,778
Massachusetts	937,247	2.93312	3,397,859	400,415
Michigan	1,172,400	3.66903	4,250,370	500,878
Minnesota	599,802	1.87708	2,174,494	256,250
Mississippi	349,993	1.09530	1,268,845	200,000
Missouri	817,299	2.55774	2,963,002	349,170
Montana	109,043	.34125	603,900	200,000
Nebraska	261,678	.81892	948,674	200,000
Nevada	69,089	.21621	603,900	200,000
New Hampshire	121,665	.38075	603,900	200,000
New Jersey	1,111,025	3.47696	4,027,868	474,657
New Mexico	132,179	.41365	603,900	200,000
New York	2,894,291	9.05769	10,492,838	1,236,511
North Carolina	716,226	2.24143	2,596,574	305,989
North Dakota	103,079	.32259	603,900	200,000
Ohio	1,512,980	4.73488	5,485,099	646,382
Oklahoma	458,882	1.43607	1,663,608	200,000
Oregon	366,503	1.14697	1,328,702	200,000
Pennsylvania	1,971,035	6.16836	7,145,707	842,074
Rhode Island	158,677	.49658	630,900	200,000
South Carolina	336,823	1.05409	1,221,106	200,000
South Dakota	116,704	.36523	603,900	200,000
Tennessee	623,588	1.95152	2,260,729	266,412
Texas	1,639,773	5.13168	5,944,770	700,551
Utah	130,718	.40908	603,900	200,000
Vermont	70,543	.22076	603,900	200,000
Virginia	620,156	1.94078	2,248,287	264,946
Washington	511,741	1.60150	1,855,250	218,629
West Virginia	301,514	.94359	1,093,097	200,000
Wisconsin	713,269	2.23218	2,585,858	304,726
Wyoming	49,747	.15568	603,900	200,000
American Samoa	1,100	.00344	301,950	62,000
Guam	3,100	.00970	301,950	62,500
Puerto Rico	294,400	.92133	1,067,310	200,000
Trust Territory	6,400	.02003	301,950	62,500
Virgin Islands	5,500	.01721	301,950	62,500

[1] The fiscal year 1977 amount for title III is $151,000,000 distributed as follows: Area planning and social services projects $122,000,000; State agency activities $17,000,000, and model projects $12 million; area planning and social services funds have been reduced by 1 percent for Federal program evaluation of title III.

Source: Department of Health, Education, and Welfare, October 1976.

An area agency on aging must be a public or nonprofit agency capable of developing an area plan and carrying out a program which pertains to that plan and the Older Americans Act (title III). Throughout the country, various agencies have been designated as

area agencies. AoA estimates that council of governments make up about 38 percent, county or multicounty agencies make up about 25 percent, private nonprofit agencies constitute about 25 percent, city governments account for about 4 percent, and other public agencies make up approximately 8 percent of the area agencies on aging. These agencies must act as the "broker" or coordinator of services for the elderly within their geographical boundaries and facilitate delivery of these services to the elderly consumer. Such services include:

—Transportation;
—Home services (includes homemaker, home care, chore, escort and shopping services);
—Legal, tax, and other counseling services;
—Home repair and renovation;
—Information and referral;
—Outreach;
—Winterization and insulation;
—Nutrition;
—Health; and
—Education and recreation.

The 1975 amendments to the Older Americans Act require that the States must provide at least 20 percent of their title III State planning and social services funds or 50 percent of their increase in allotment of title III funds for planning and social services be used for the four priority services: transportation, legal and other counseling, home services, and home repair and renovation.[8]

Services were provided, by AoA count, to approximately 1,392,000 elderly persons in fiscal year 1976. As required by law, service providers reportedly gave emphasis to low-income and minority elderly serving approximately 17 percent minority and 42 percent low-income older persons. These AoA projections are rough estimates of the clientele served, as the Older Americans Act does not require any form of means test (income eligibility determiner). The only requisite is that he or she be 60 years of age or older.

MODEL PROJECTS

To complement the development of Older Americans Act programs and to "test" programs programatically for future operation, title III supports model or demonstration projects. Model project funds support all or part of "the cost of developing or operating statewide, regional, metropolitan area, county, city, or community model projects which will expand or improve social services or otherwise promote the well-being of older persons."[9] Such projects have been known to be forerunners for established programs under the Older Americans Act. For example, title VII, the nutrition program for the elderly, was a demonstration project under title III in the early 1970's. The effectiveness and popularity of the scattered demonstration projects gave impetus to legislative initiative to create a distinct title under the act to support a nationwide nutrition program.[10]

[8] For a detailed description of the provisions of the 1975 amendments, see *Developments in Aging: 1975 and January–May 1976* (part 1), chapter I, section II, p. 15.

[9] Older Americans Act of 1965, as amended, Public Law 89–73, section 308(a), model projects.

[10] Title VII was originally introduced as legislation by Senators Edward Kennedy and Charles Percy in 1971 and was signed into law on Mar. 22, 1972 (Public Law 92–258).

Model projects have also supported projects which demonstrate service delivery for transportation, housing, legal services, nursing home ombudsman programs, and continuing education programs for the elderly. During fiscal year 1976, 164 model projects were supported throughout the Nation. In addition, each State received a modest amount for State model projects. Such projects included a nursing home ombudsman in each State, a legal services coordinator at the State level, several demonstrations of service delivery in the rural areas, and a television series for the elderly. Private organizations were also funded to give special emphasis to elderly participants of their respective programs. For example, the American Association of Community and Junior Colleges and the Adult Education Association were funded to give emphasis to programs for the older student. The National Center for Voluntary Action was supported by title III to study the use of volunteers in providing home care for the aging. Title III is also supporting a model project under the auspices of the American Society for Public Administration (ASPA) to test their capacity to fill available public service, administrative, and technical positions with semiretired persons.

C. Evaluation of Title III

During fiscal year 1976, area agencies on aging had been operating for about 3 years, some at full capability and others still in early stages. Therefore, any evaluations of the area agency concept and title III are based on varying levels of progress. To analyze the progress and effectiveness of the title III programs, the Administration on Aging may tap up to 1 percent of each title's appropriations for evaluation. Accordingly, the AoA has made the following arrangements for evaluation of area agencies on aging and the title III concept:

—A longitudinal evaluation of area agencies on aging which will include an analysis and review of 40 area agencies during the first year to be followed by a similar study of 40 different area agencies during the second year; the third and fourth years will consist of followup reviews of the first and second set of area agencies on aging (Westat of Bethesda, Md., is the contracting research grantee);

—An evaluation of the information and referral (I. & R.) services provided under title III to determine how well the States and area agencies are achieving the standards of I. & R. as prescribed by the law in providing accessible and convenient inservice delivery for the elderly consumer (Mark Battle Associates of Washington, D.C., is the grantee);

—A coevaluation with the Social and Rehabilitation Services Administration (SRS) to determine what emphasis the elderly consumer is given by title XX social service and the effects on the delivery of services to the elderly (Urban Institute of Washington, D.C., is the contracting research grantee);

—An evaluation of interagency agreements and the State and area agencies' success in entering into such agreements and their effectiveness (the National Institute for Advanced Studies of Washington, D.C., will be the contracting organization); and

—Several title IV(B) research grants awarded to various universities and colleges to study both specific and general aspects of the delivery of services under title III, the effects of an area agency on the community, and the relationships of the area agency with other service providers and political entities within its service area.

In addition, several units[11] of the House of Representatives and the Senate requested the General Accounting Office to conduct an update of its 1974 review of 28 area agencies on aging, 17 State agencies on aging, and 9 regional offices. The GAO analysis will examine such issues as the relationship of the area agency with other local agencies, political subdivisions, State agency on aging, and Federal regional offices; the effectiveness of guidance and policy from the State and regional levels; the effectiveness of the area agencies in serving the poor and minority elderly; and the programmatical and fiscal effects of the 1975 mandated priority services on the State and area agencies. It is anticipated that this analysis will be presented to the Congress prior to the time when the legislation must be considered to extend the Older Americans Act which expires on September 30, 1978.[12]

D. Program Progress in Title VII

Title VII, the nutrition program for the elderly, received considerably broadened funding in 1976. In addition to an appropriation of $125 million for fiscal year 1976, the Congress directed that the level of operations for the program be $187.5 million. This level was to be reached in the States by utilizing carryover funds from previous fiscal years. When the Department of Health, Education, and Welfare attempted to keep the level at $187.5 million by the end of the fiscal year, a Federal court stepped in and ordered that the full amount of $187.5 million be *spent* in fiscal year 1976.[13]

This influx of new funds was significantly enhanced by the fiscal year 1977 appropriations. The Congress provided for $203.525 million for title VII for fiscal year 1977 with an operating level of $225 million.[14] These funds have been allotted to the 50 States and territories according to their 60-and-over population and must, according to the court order, be spent by the States by September 30, 1978. If the States are unable to spend their full allocations, a reallotment of the fiscal year 1977 funds will be implemented by AoA in May of 1977.

The fiscal year 1977 funds were allotted to the States in the following amounts:

[11] Chairman of the Select Education Subcommittee of the House, the House Select Committee on Aging, the Subcommittee on Aging of the Senate, and the Senate Special Committee on Aging requested the up-dated study in a joint letter sent Dec. 16, 1976.

[12] In accordance with the Congressional Budget Impoundment Control Act of 1974 (Public Law 93-344) any legislation which authorizes the enactment of new budget authority for a fiscal year must be reported in the House or Senate on or before May 15 prior to such fiscal year. Therefore, the legislation to extend the Older Americans Act must be reported on or before May 15, 1978.

[13] *Kennedy* v. *Mathews*, the U.S. District Court of the District of Columbia held on May 17, 1976 that the Department of Health, Education, and Welfare had to release the full $187.5 million during fiscal year 1976 and further directed that all funds appropriated for fiscal years 1976 and 1977 must be spent by the States by Sept. 30, 1977.

[14] In addition to the $203.525 million included in the Labor-HEW appropriations for fiscal year 1977, title VII projects are eligible for 27.25 cents in commodities for each meal served during fiscal year 1977. These funds are provided from the USDA.

FISCAL YEAR 1977 STATE ALLOTMENT AMOUNTS UNDER TITLE VII OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

[Available for obligation through Sept. 30, 1977]

States	Population 60+, July 1, 1975		Title VII nutrition [1]
	Unrounded population	Percent distribution	
Total 56 "States"	31,953,950	100.0000	$201,489,750
Alabama	534,897	1.6740	3,234,752
Alaska	15,784	.0494	1,007,448
Arizona	317,967	.9951	1,922,888
Arkansas	373,967	1.1703	2,261,540
California	2,930,960	9.1724	17,724,803
Colorado	302,076	.9453	1,826,790
Connecticut	462,346	1.4469	2,796,002
Delaware	72,045	.2255	1,007,448
District of Columbia	101,987	.3192	1,007,448
Florida	1,781,967	5.5767	10,776,331
Georgia	618,320	1.9350	3,739,243
Hawaii	87,768	.2747	1,007,448
Idaho	115,304	.3608	1,007,448
Illinois	1,643,227	5.1425	9,937,304
Indiana	746,877	2.3373	4,516,684
Iowa	493,705	1.5450	2,985,647
Kansas	385,756	1.2072	2,332,826
Kentucky	515,411	1.6130	3,116,915
Louisiana	492,108	1.5400	2,975,985
Maine	172,919	.5411	1,045,716
Maryland	500,390	1.5660	3,026,073
Massachusetts	937,247	2.9331	5,667,947
Michigan	1,172,400	3.6690	7,090,016
Minnesota	599,802	1.8771	3,627,261
Mississippi	349,993	1.0953	2,116,553
Missouri	817,299	2.5577	4,942,565
Montana	109,043	.3412	1,007,448
Nebraska	261,678	.8189	1,582,477
Nevada	69,089	.2162	1,007,448
New Hampshire	121,665	.3807	1,007,448
New Jersey	1,111,025	3.4770	6,718,861
New Mexico	132,179	.4136	1,007,448
New York	2,894,291	9.0577	17,503,038
North Carolina	716,226	2.2414	4,331,329
North Dakota	103,079	.3226	1,007,448
Ohio	1,512,980	4.7349	9,149,660
Oklahoma	458,882	1.4361	2,775,055
Oregon	366,503	1.1470	2,216,399
Pennsylvania	1,971,035	6.1684	11,919,710
Rhode Island	158,677	.4966	1,007,448
South Carolina	336,823	1.0541	2,036,919
South Dakota	116,704	.3652	1,007,448
Tennessee	623,588	1.9515	3,771,108
Texas	1,639,773	5.1317	9,916,435
Utah	130,718	.4091	1,007,448
Vermont	70,543	.2208	1,007,448
Virginia	620,156	1.9408	3,750,354
Washington	511,741	1.6105	3,094,731
West Virginia	301,514	.9436	1,823,389
Wisconsin	713,269	2.2322	4,313,454
Wyoming	49,747	.1557	1,007,448
American Samoa	1,100	.0034	507,724
Guam	3,100	.0097	507,724
Puerto Rico	294,400	.9213	1,780,374
Trust Territory	6,400	.0200	507,724
Virgin Islands	5,500	.0172	507,724

[1] The fiscal year 1977 amount for title VII is $203,525,000; distributed as follows: nutrition projects $201,489,750; Federal program evaluation $2,035,250. (13.635)

Source: Department of Health, Education, and Welfare.

These increased spending levels for title VII affected the program's participation and project number. In fiscal year 1976, 809 nutrition projects were operational and administered 6,145 sites in all the States. The sites served about 275,000 meals daily and are estimated by AoA to increase this number to 410,000–450,000 meals per day by the end of fiscal year 1977.

The 275,000 meals were served to approximately 1,713,000 elderly persons during fiscal year 1976. These persons are described by the AoA as being 62 percent urban, 38 percent rural, 20 percent minority, and 55 percent low income. The meals are served in congregate sites, where elderly volunteers often prepare and serve the meals. Some projects contract to have catering services provide the meals while other projects prepare the meals on site. The meals are served 5 days a week and must adhere to the dietary recommendations of the guidelines for title VII.

In addition to congregate meals, title VII allows States to use a small percentage of their title VII allocations for home-delivered or meals-on-wheels. Such meals are delivered in insulated containers to elderly persons who are homebound. Efforts are made to coordinate the home-delivered meals with the congregate meals in order that the elderly recipient may be assimilated back into the socialization of congregate meals after illness or immobility. Often, the home-delivered meal is provided to a person who formerly participated in the congregate program but can no longer visit the site.

Senator George McGovern introduced legislation (S. 3585) during the 94th Congress (June 1976) which would provide for a broader national meals-on-wheels program. This program would be within the title VII program but set aside $80 million for a national program for fiscal year 1977 and $100 million for fiscal year 1978. The bill received bipartisan support from Members of Congress and from the aging field. It was reintroduced in the 95th Congress as S. 519.

Senator McGovern's introductory statement said:

> The evidence clearly indicates that for several million persons, a home-delivered nutritious meal often makes the difference between additional years in their homes or institutionalization in costly nursing homes. When a senior can no longer shop or prepare meals, when hunger becomes a daily experience, there is currently no alternative available other than the nursing home or hospital. A meals-on-wheels program would therefore reduce spending in the health care sector. . . . The cost of a nursing home is generally over $20 per day, while a home-delivered meal costs under $2.[15]

E. Evaluation of Title VII

The popularity of the title VII program is seen in every host community. Since its implementation in 1973, the program's visibility and effectiveness have increased in every State. This popularity is reflected in the congressional support expressed by the levels of appropriations for the program over the last 2 years.

An extensive evaluation of title VII was begun during 1976. AoA subcontracted with Kirschner Associates of Washington, D.C., to do an extensive analytical evaluation of the title VII program and effectiveness. In addition, AoA contracted with Opinion Research of the Gallup Poll to conduct an extensive interviewing survey of 7,200

[15] Opening remarks by Senator George McGovern when presiding at the Senate Select Committee on Nutrition and Human Needs' hearing on "The Homebound Elderly—Our Most Dependent Citizens," June 17, 1976.

elderly participants and nonparticipants of title VII programs. Results of this evaluation are not expected before October 1977.

Complementing this extensive program evaluation are several State- and university-based analyses of the title VII program. For example, one study supported by the Missouri office on Aging revealed that nutritional deficiencies can be improved and/or eliminated by nutrition programs that are based on sound nutrition principles.

The Missouri study states:

> The provision of 50 percent of the recommended dietary allowances (RDA) for a nutrient by a program meal could potentially give as much as one-third of the weekly allowances for that nutrient if the person were to participate in the program five times a week. If 80 percent of the RDA for a nutrient were provided in each meal (as was the case for vitamins A and C, according to the menu used in central Missouri) eating the program meal three times a week would mean that one-third of the allowance for the nutrient would be met.[16]

More than 400 elderly persons participated in this evaluation in central Missouri. During 1974, participants were randomly selected and food records were taken to list the participants' intake. In addition, each participant was invited to attend a clinic during the term of the study in order that blood samples could be taken to analyze "hematocrit, hemoglibin, serum iron, serum vitamin C, serum vitamin A, serum cholesterol and glutathione reductase." Elderly attending the clinic had their weight, height, triceps skinfold, blood pressure, and heart rate measured. Medical histories were also submitted. Evidence derived from the elderlys' participation rate, clinical studies, and medical histories showed that those elderly participating more often in the program indicated better nutritional status and health.

F. Emergence of Title V Senior Centers

Although created by the 1973 amendments to the Older Americans Act, title V, multipurpose senior centers, had no appropriation until the transitional quarter of fiscal year 1976 (June 30, 1976, through September 30, 1976). The Congress provided $5 million for title V for allotment to the States in accordance with their 60-and-over population at a 75–25, Federal to local match. These funds are provided for the acquisition, renovation, or alteration of a facility that will serve as a multipurpose senior center. These centers are to be coordinated with the comprehensive service systems for older persons as sponsored by the State and area agencies on aging (title III).

The transitional quarter appropriations of $5 million was used to fund 549 centers throughout the country. Of the 549 centers, 339 were existing centers and 210 were newly established; 457 centers were funded for alteration and/or renovation purposes; 69 were funded for equipment; and 23 were funded for acquisition purposes. The final program regulations, issued on September 10, 1976, instructed:

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[16] *Contribution of the Nutrition Program for Older Americans to Nutritional Status*, by Mary Bess Kohrs, Ph. D., and Pauline O'Hanlon, M.S., and Esther Lorah, Ph. D. at the Human Nutrition Research Program, Department of Agriculture and Natural Resources, Lincoln University, Jefferson City, Mo.; funded by the Central Missouri Area Agency through the Missouri Office of Aging and USDA. (Paper delivered at annual scientific meeting, Gerontological Society, New York City, October 1976.)

> The programs to be conducted in such facilities shall be coordinated with State and area agencies on aging who are charged under the Older Americans Act, with the responsibility for developing comprehensive systems of services for older Americans. The title V program will be an integral part of the overall planning and service delivery scheme of State and area agencies on aging. Title V applications will be reviewed by both State and area agencies, which shall transmit such applications to the Commissioner (AoA) after first having recommended and ranked them.[17]

Title V was allocated $20 million for fiscal year 1977. These funds will substantially increase the number of title V centers throughout the country and provide a central point within the community for services to the elderly.

Applicants for senior center funds have been frustrated because title V does not provide funding for construction and operational costs. Title V provides only for funds for alteration, acquisition, or renovation, and are allocated on a one-time, capital outlay basis.

Actual construction funds can be obtained from the local public works capital development and investment program of the Economic Development Act, from the community development block grant program, and from the general revenue-sharing program. Communities across the country have been successful in securing construction funds from these various sources, to some degree.

Operational or ongoing program costs for senior centers have been funded under title III of the Older Americans Act, title XX social services, community education programs, and other State and local service providing programs. These services are oftentimes coordinated with the area agencies on aging and are provided to the elderly consumer at the center site.

II. THE SECOND YEAR OF TITLE XX

Title XX began its second year of operation in 1976.[18] Title XX is the most recent revision of the social services program under the Social Security Act which provides funding for services to eligible low-income families and individuals. Title XX has been described as providing the most flexibility in providing services than any other Federal program. One researcher labeled the program as "a blank sheet on which each State can write its own services script." [19]

Title XX might appear as a "blank sheet," since the program provides for no mandated services but merely asks the States to meet five specific goals:

> (1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
>
> (2) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
>
> (3) Preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;

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[17] *Federal Register*, vol. 41, No. 177, Sept. 10, 1976.

[18] Title XX became law (Public Law 93-647) on Jan. 4, 1975, and became operative on Oct. 1, 1975.

[19] "Title XX, Community Mental Health and the Aged," a presentation by Harry Maney, MSW, at the annual gerontological conference, New York City, October 1976.

(4) Preventing or reducing inappropriate institutional care by providing for community-based care, or other forms of less intensive care; or

(5) Securing referral of admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

Title XX also opened the scope of eligibility for social services. The law provides that services be provided free of charge to those recipients of welfare assistance. In addition, title XX services can be provided to individuals with incomes up to 80 percent of the median income of their State, with the State having the option to charge for these services. For those families and individuals with incomes between 80 percent and 115 percent of their State's median income, services may be provided for a small fee. No person whose income exceeds the 115 percent of the State median income level is eligible for title XX services.

A. Title XX Problems

Title XX broadened the scope and flexibility of the Nation's largest social services program, but it retained the $2.5 billion ceiling installed by the Congress in 1972.[20] This ceiling has been widely criticized by State officials and service providers who are unable to meet the demand for services even when the total local and/or State match of 25 percent is met. Unlike past history, States are able to utilize most of their Federal title XX funds as they are able to put up their share of the match (25 percent). However, the problem has emerged that even after coming up with their 25 percent, many States are still in need of additional funds to meet the needs of those potential title XX recipients.

According to a study by the National Council on the Aging, the Federal ceiling has had varying effects on the 50 States and territories. The study says:

> Although the $2.5 billion Federal ceiling and matching requirement set the Federal participation limit, States could expend more than their 25 percent match for social services. And a few States were most responsive to the demand for needed services, even though the costs exceeded available funds in the total 75–25 Federal/State partnership. These few States were able to generate non-Federal funds over and above what was required for matching purposes to support additional needed services. In several other instances, States acquired sufficient match to draw down their full Federal allotments, holding their social services spending limits to the combined Federal/State ceiling.[21]

Another problem of title XX in 1976 was the eligibility determination. When the proposed regulations for title XX were published in April 1975, they required that eligibility be continually determined and that "no determination shall be made solely on the basis of the applicant's declaration as to income status or current family monthly

[20] Public Law 92–512 included a congressional mandate that placed a $2.5 billion ceiling on the annualized Federal support for social services under the Social Security Act.

[21] "Making Title XX Work, A Guide to Funding Social Services for Older People," a publication of the National Council on the Aging, 1976.

gross income." [22] This provision of the proposed regulations was highly criticized and resulted in the final regulations of June 1975, which allowed some States to use the group eligibility method until December 31, 1975, at which time all persons receiving title XX services would have to be individually certified eligible for services.

However, this did not please many of the service providers and constituents.[23] Title XX recipients, especially older persons who participated in senior center activities funded by title XX, aggressively objected to having their income "tested." The means test, as it became known, was the thorn in the side for HEW and was the impetus for the publication of regulations on October 3, 1975, February 9, 1976, and April 2, 1976, further modifiying the determination of eligibility provisions of the regulations.

These regulations did not fully satisfy those opposed to the means test, and Congress acted. The House of Representatives passed legislation (H.R. 12455) which would have allowed the States to use group eligibility determinations through September 30, 1976. The Senate drastically modified H.R. 12455 by proposing to eliminate from the law the requirement that Federal funding under the program be limited to individuals with income below 115 percent of their State's median income. Further, the Senate Finance Committee gave the States complete flexibility to determine who would be eligible for services under title XX.

As reported from the joint conference between the House of Representatives and the Senate, the agreement differed from both original versions. The conferees agreed to give the States the option of waiving individual eligibility determinations and using group eligibility instead for most services. Group eligibility can be used for a service if a State can "reasonably conclude, without individual determination of eligibility," that substantially all of the persons who receive the title XX services come from families whose incomes are below 90 percent of the State's median income for families of that size.[24] The new group eligibility provision can be used for all services with the exception of child care services under title XX.

This new law could allow the States to provide that senior centers and other similar service programs to dispense with the individual determination of income or means test. However, the new law does give the State the option to make this decision about what form of determination they will use and for what services. Therefore, it is possible that some States will continue to administer some form of eligibility determination that will be similar to a means test.

B. Coordination of Title XX and Other Service Programs

A funding of $2.5 billion places title XX in the position of being the chief source of funding for social services in the country and within each State. The States receive their title XX allocation on the basis of their population. Amounts range from California at approximately $245 million for fiscal year 1976, to $4 million for Alaska.

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[22] *Federal Register*, p. 16809, Apr. 14, 1975.
[23] For a detailed description of the opposition, see *Developments in Aging: 1975 and January-May 1976*, part 1, U.S. Senate Committee on Aging, June 26, 1976.
[24] Public Law 94-401, signed into law on Sept. 7, 1976 (H.R. 12455).

ESTIMATED FEDERAL SHARE OF STATE EXPENDITURES FOR SOCIAL SERVICES FOR FISCAL YEARS 1976 AND 1977: BY STATE

[In millions]

State	Full allocation under $2,500,000,000 limit: Fiscal year 1976 [1]	Amount to be used by State: Fiscal year 1976 [2]	Full allocation under $2,500,000,000 limit: Fiscal year 1977	Amount to be used by State: Fiscal year 1977 [3]	Change: Fiscal year 1976 to fiscal year 1977 increase (+) or decrease (−) in State allocation [4]
Alabama	$42.25	$42.25	$42.30	$36.34	+
Alaska	4.00	3.90	3.98	3.98	−
Arizona	24.50	9.55	25.40	10.48	+
Arkansas	24.25	19.76	24.38	18.79	+
California	245.50	245.50	247.25	247.25	+
Colorado	29.00	29.00	29.52	29.52	+
Connecticut	36.75	36.75	36.52	36.52	−
Delaware	6.75	6.75	6.78	6.78	+
District of Columbia	9.00	9.00	8.55	8.55	−
Florida	91.50	91.50	95.68	95.68	+
Georgia	57.00	57.00	57.72	57.72	+
Guam				.55	
Hawaii	10.00	10.00	10.02	10.02	+
Idaho	9.25	9.25	9.45	9.45	+
Illinois	133.75	133.75	131.65	131.65	−
Indiana	63.25	30.60	63.02	38.28	−
Iowa	34.50	34.50	33.78	33.78	−
Kansas	27.25	27.25	26.85	21.54	−
Kentucky	39.75	39.75	39.70	39.70	−
Louisiana	44.75	44.75	44.52	44.52	−
Maine	12.25	12.25	12.38	12.38	+
Maryland	48.50	48.50	48.42	48.42	−
Massachusetts	69.25	69.25	68.60	68.60	−
Michigan	107.75	107.75	107.58	107.58	−
Minnesota	46.50	46.50	46.32	46.32	−
Mississippi	27.25	12.60	27.48	7.73	+
Missouri	56.75	54.05	56.50	30.94	−
Montana	8.50	8.50	8.70	8.70	+
Nebraska	18.25	18.23	18.24	18.25	No change
Nevada	6.50	6.30	6.78	3.36	+
New Hampshire	9.50	9.22	9.55	9.55	+
New Jersey	87.75	87.75	86.70	86.70	−
New Mexico	13.25	13.25	13.28	13.28	+
New York	217.50	217.50	214.20	214.20	−
North Carolina	62.75	62.75	63.42	52.18	+
North Dakota	7.50	7.50	7.52	5.67	+
Ohio	127.75	127.75	126.98	126.98	−
Oklahoma	31.75	31.75	32.05	32.05	+
Oregon	26.50	26.50	26.80	26.80	+
Pennsylvania	141.75	141.75	139.08	139.98	−
Puerto Rico				18.28	
Rhode Island	11.50	11.50	11.08	11.07	−
South Carolina	32.50	32.50	32.92	32.92	+
South Dakota	8.25	7.68	8.08	8.08	−
Tennessee	49.25	49.25	48.82	39.77	−
Texas	140.50	140.50	142.50	142.50	+
Utah	13.75	13.75	13.88	13.88	+
Vermont	5.50	5.50	5.55	5.55	+
Virgin Islands				.53	
Virginia	57.25	57.25	58.05	39.75	+
Washington	40.75	40.75	41.10	41.10	+
West Virginia	21.50	21.50	21.18	16.14	−
Wisconsin	54.50	54.50	54.00	54.00	−
Wyoming	4.25	3.71	4.25	4.25	No change
Total	2,500.00	2,428.85	2,500.00	2,400.00	

[1] The State allocations are determined annually on a population basis.

[2] These were determined from an analysis (by HEW) of the 51 final comprehensive annual services program (CASP) plans, effective Oct. 1, 1975. However, for budgetary purposes, HEW is assuming that the States will only use $2,260,000,000 in fiscal year 1976 (from the fiscal year 1976 budget appendix).

[3] HEW has estimated, for budget purposes, that in fiscal year 1977 the States have underestimated their use of reimbursable funds by $31,432,000, which brings their budget request to $2,400,000,000.

[4] This indicates whether a State allocation changed between fiscal year 1976 and fiscal year 1977 due to a shift in its relative population.

Source: U.S. Department of Health, Education, and Welfare.

With most of their Federal social services money coming from title XX, the States must develop a system under which title XX not only supports the entire operation of a program but acts as a major supplement to many other Federal and State programs. As mentioned earlier in this chapter, the States must put up a 25 percent match for their Federal allocation, while attempting to also maintain some freestanding State programs. Some States are able to support both Federal and State programs while others must depend on their match to title XX to support their full social services system for their State.

For the elderly, title XX has developed into a financial root for the services they require. Under the concept of title III and the area agency on aging, the State and area agency must pool other services and resources. In many instances, title XX has become this chief means of support. Title XX has been used by several State agencies on aging to fully fund their home health program, their legal services program, their transportation program, and their meals-on-wheels program, which are then pooled by title III. Other States have used their title XX funds to supplement the aging network within their boundaries.

However, the elderly do not fit squarely into the needs design as established by title XX. The elderly often cannot be absorbed back into the work class, which is the major philosophy of title XX: to keep the individual off welfare and fit for gainful employment. Therefore, the elderly clientele are forced to utilize a wide array of services for indefinite periods of time with no relief in sight. Their justification and need for such services are obvious. This cause has been widely acclaimed by the aging advocates and network within each State and has been the chief reason for the emergence of title XX as a growing source of support for elderly service programs.

Title XX requires that a State plan be developed by the State and approved by the Governor. This plan lays out the goals and operations of the State's title XX program. The public has opportunity to view and react to the plan and make constructive comments. The elderly advocates have been quite successful in some States by using this tool to its full advantage. By making their opinions known to the State, the Governor, their legislatures, and service agencies, the elderly advocates have become a most important impetus to better service systems for the elderly. (For further discussion of States' use of title XX funds for the elderly, see chapter XII.)

III. OTHER SOURCES OF FUNDING

Federal sources of funding available to the aging "network" under the Older Americans Act and title XX of the Social Security Act, discussed above, can be supplemented in ways recommended by the Administration on Aging. Two potentially major sources are general revenue sharing and community development block grants.

A. General Revenue Sharing

Historically, States have applied significantly small portions of general revenue sharing funds to social services, including services

for the elderly.[25] Surveys of State offices on aging undertaken by the Senate Committee on Aging in March and December 1976 have also indicated that the experiences of State and area agencies on aging in obtaining State and local allocations of general revenue sharing funds for older Americans has not been highly successful.[26]

RECENT CHANGES IN THE LAW

The General Revenue Sharing Amendments of 1976 (Public Law 94–488, enacted October 13, 1976) extended the general revenue sharing program through September 30, 1980, and authorized an annual base of $6.65 billion plus annual increments of up to $200 million for allocations to State and local units of government.

A number of changes were made to the law which could have a direct effect on the use of these funds for programs and services for older Americans.

—Repeal of matching prohibition: Section 104 of the law, which prohibited the use of general revenue sharing funds as matching money for other Federal programs, was repealed. This could have the effect of freeing some of these funds for use as local match shares for Older Americans Act programs (title III and title VII) as well as title XX social services and Federal transportation funds such as section 16(b)(2) of the Urban Mass Transportation Act which provides grants to private, nonprofit sponsors for specialized transportation programs for the elderly.

—Prohibition of age discrimination in use of funds: The 1976 amendments significantly strengthen the nondiscrimination provisions of the act by including a general prohibition against discrimination on the basis of race, color, national origin, or sex and add new prohibitions against discrimination on the basis of age and handicap. The age discrimination provisions are tied to the Age Discrimination Act of 1975 and will become effective no earlier than January 1, 1979.

—Participation of elderly in allocation decisions: The 1976 amendments also strengthen the act's citizen participation provisions by requiring each unit of government receiving funds to hold a public hearing on their planned use at least 7 days before the budget is presented to the governmental body responsible for its enactment at a time and place which permits and encourages public attendance and participation. A second hearing is required before the budget is adopted. The amendments and regulations issued by the Office of Revenue Sharing[27] also specifically direct re-

[25] The first actual use reports issued by the Office of General Revenue Sharing, Department of the Treasury, showed that less than 3 percent of total allocations had been used for social services for the poor and the aged through June 30, 1973. A subsequent report, covering the period July 1, 1974, through June 30, 1975, reported only 2 percent of the total allocations had gone for social services. An analysis of funds spent specifically on programs for the elderly in 219 local governments prepared by the General Accounting Office revealed that less than one-half of 1 percent of funds had been spent on programs for the elderly. See, *Developments in Aging: 1975 and January–May 1976*, part 1, Special Committee on Aging, U.S. Senate Report No. 94–998, p. 173, for a detailed analysis of general revenue sharing funds allocated to programs and services for older Americans.

[26] See report cited in footnote 25, p. 212, for a discussion of uses of revenue sharing funds reported by some States during 1974 and 1975. See chapter XII, p. 178 of this report for uses reported during 1976.

[27] Proposed regulations on public participation and public hearings were issued by the Office of Revenue Sharing on Oct. 27, 1976. *Federal Register*, vol. 41, No. 208, p. 47054. Interim regulations were issued on Jan. 10, 1977. *Federal Register*, vol. 42, No. 6, p. 2196.

cipient governments to make reasonable efforts to provide senior citizens and organizations representing senior citizens with an opportunity to be heard and present their views regarding the allocation of funds during the conduct of any hearing or proceeding on revenue sharing allocations or on its own budget process. These provisions became effective on January 1, 1977.

This new provision of the law, introduced in the House by Representative William J. Randall, chairman of the House Select Committee on Aging, and successfully retained in the Senate, can potentially be of major significance for funding of State and local programs for older Americans through general revenue sharing funds.

—Repeal of priority spending categories: The amendments also repealed section 103 of the law which listed priority expenditure categories for revenue sharing funds—one of which was social services for the poor and aged. As indicated above, however, even the designation of such a priority category did not have much effect on actual expenditures by local units of government for social services, as the final decision was left to the locality, but the elimination of the priority categories makes the active participation of the elderly in the public hearing process of particular importance.

B. Community Development Block Grants

The community development block grant program does provide funds for programs which assist elderly persons, but it must be remembered that these programs are generally more "property oriented" than social service tailored.

Although social services activities are not exempt from community development funding, they must be used in support of other community development activities. For instance, social services could be provided to displacees of a building demolished by urban renewal activities.

Authorized activities under the block grant program could include such activities as the removal of architectural barriers or the modernization of a public housing facility to include congregate dining, both of which would benefit elderly persons directly.

For fiscal year 1976, estimated expenditures under the community development block grant program are $2.34 billion. Of this, approximately $18 million (or less than 1 percent) can be identified as going exclusively for elderly activities. However, these figures are deceptive of the benefits under the program since elderly persons benefit from activities which are geared toward serving the community in general. The development of community centers, improved sewage systems, and code enforcement could all result in enhancement of the living conditions of elderly persons.

The Brookings Institute has been monitoring the use of block grant funds in several communities to include the responsiveness of the program to elderly concerns, and these findings should be available early in 1977.

FINDINGS AND RECOMMENDATIONS

1976 proved to be a significant year for the Older Americans Act. The substantial increases in appropriations for most of the act's titles were clearly justified to meet the necessary growth of the programs.

The committee urges that continual congressional support of the Older Americans Act be shown by allowing for a growth of resources in accordance with the need. The increasing number of area agencies on aging, nutrition projects, senior centers, and elderly persons themselves should be further recognized. Training of personnel—to serve the elderly and research to provide a knowledge base for new stages of network development—should have high priority under title IV.

The committee recommends that the Congress give careful consideration to raising the ceiling placed upon title XX social services under the Social Security Act in 1972 to take into account the cost of inflation and growth of the program.

The committee supports the placement of the Administration on Aging directly within the Office of the Secretary of HEW in order better to fulfill its responsibility as an advocate for the elderly.

CHAPTER VI

RECESSION'S CONTINUING EFFECTS ON OLDER WORKERS

Our Nation demonstrated some modest recovery in 1976 from the worst recession in nearly 40 years. But the economic upturn provided little improvement for middle-aged and older workers. And in some key barometer areas their situation actually deteriorated.

Massive layoffs in 1974 and 1975 caused a substantial increase in unemployment for all age groups. But many older workers never recovered from the recession. Large numbers were forced into early retirement in 1976, after exhausting unemployment benefits. Others found themselves going steadily down the occupational ladder in attempting to remain employed.

But despite these disturbing developments, 1976 produced some potentially encouraging legislative developments for older workers. Congress rejected the Ford administration's recommendation to terminate the Title IX Older American Community Service Employment Act, and approved, instead, major funding increases for this program. An amendment with important implications for older workers was included in legislation to extend the title VI emergency public service jobs program under the Comprehensive Employment and Training Act. And, the title X job opportunities program (Public Works and Economic Development Act) was continued, despite administration opposition.[1]

I. THE RECESSION'S CONTINUING VICTIM

A working paper[2]—prepared for the Committee on Aging by Dr. Marc Rosenblum—provided alarming evidence about the impact of the 1974–75 recession on older workers. Dr. Rosenblum's well-documented findings disclosed that older workers made little or no progress during the recovery. In fact, he concluded:

> *Viewed in its totality, there is clear and convincing evidence that older workers are worse off now [first quarter in 1976] than in the prerecession peak period, the fourth quarter in 1973.*[3]

Unemployment actually increased (by 34,000) among persons 55 or older since the United States bottomed out of the trough of the recession during the first quarter in 1975. In sharp contrast, joblessness declined by 400,000 from the first quarter in 1975 to the first quarter in 1976 for individuals under 55.

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[1] For more detail discussion of these legislative actions, see pp. 89–91.
[2] *Recession's Continuing Victim: The Older Worker*, a working paper prepared for use by the U.S. Senate Special Committee on Aging, 94th Cong., 2d sess., July 1976.
[3] Page 1 of working paper cited in footnote 2.

From the fourth quarter in 1973 to the first quarter in 1976, unemployment more than doubled for persons aged 55 or older—increasing from 376,000 to 763,000. However, these figures do not fully represent the total impact because of the significant "hidden unemployment"[4] among older workers.

For example, the report revealed that labor force participation for persons 55 or older declined by over 400,000 from the first quarter in 1975 to the first quarter in 1976. Dr. Rosenblum concluded that one out of three of these individuals withdrew from the labor force involuntarily.

He added:

> *Many older workers are at a competitive disadvantage which, if not recognized, may lead to permanent economic dislocation for a whole class of Americans; a class presently composed of those born prior to, during, and shortly after World War I. Signs of this dislocation are becoming evident. The increasing poverty of older persons is but one, albeit visible and a very disturbing sign.*[5]

The 1976 census poverty figures provided further support for Dr. Rosenblum's findings. Poverty among persons 45 or older increased by 500,000 from 1974 to 1975,[6] the sharpest increase in history. More than 7 million persons in this age category had incomes below the poverty line in 1975, or almost 11 percent of all middle-aged and older Americans. In addition, 3.7 million persons 45 or older were marginally poor (incomes below 125 percent of the poverty thresholds). The net impact is that 10.8 million middle-aged or older persons—or almost 17 percent of the 45-plus population—live in official poverty or very close to it.

POVERTY AMONG PERSONS AGED 45 OR OLDER AND AMONG INDIVIDUALS AGED 45 TO 64

[In thousands]

	1975	1974
45 or older:		
Total number (noninstitutionalized)	64,881	64,199
Number poor	7,033	6,522
Percent poor	10.8	10.2
45 to 54:		
Total number (noninstitutionalized)	23,452	23,586
Number poor	1,707	1,629
Percent poor	7.3	6.9
55 to 59:		
Total number (noninstitutionalized)	10,561	10,362
Number poor	953	881
Percent poor	9.0	8.5
60 to 64:		
Total number (noninstitutionalized)	9,206	9,124
Number poor	1,056	927
Percent poor	11.5	10.2

Source: Bureau of the Census.

[4] The unemployment figures, for example, include only those persons actively seeking employment. They do not include persons who have dropped out of the labor force after a prolonged and fruitless search for a job.

[5] Page 2 of working paper cited in footnote 2.

[6] The 1976 Bureau of the Census poverty figures are based upon a survey in March 1976 for 1975 income. The 1976 poverty data will be based upon a March 1977 Bureau of the Census survey.

PERSONS WITH INCOMES BELOW NEAR POOR STANDARDS (125 PERCENT OF POVERTY THRESHOLDS), REVISED FIGURES

[In thousands]

	1975	1974
45 or older:		
Total number (noninstitutionalized)	64,881	64,199
Number near poor	10,762	10,092
Percent near poor	16.6	15.7
45 to 54:		
Total number (noninstitutionalized)	23,452	23,586
Number near poor	2,397	2,232
Percent near poor	10.2	9.5
55 to 59:		
Total number (noninstitutionalized)	10,561	10,362
Number near poor	1,356	1,230
Percent near poor	12.8	11.9
60 to 64:		
Total number (noninstitutionalized)	9,206	9,124
Number near poor	1,514	1,402
Percent near poor	16.4	15.4

Source: Bureau of the Census.

Annual poverty thresholds (1975, for persons under 65)

Individual	$2,791
Two-person family where head is under 65	3,599
Three-person family	4,269
Four-person family	5,469

Source: Bureau of the Census.

Once unemployed, the older worker is much more likely to be without a job for a longer period than the younger unemployed worker. The mean duration of unemployment for middle-aged and older persons (both sexes) is typically 20 percent to 58 percent longer than for all workers. During the first quarter in 1976, the average length of unemployment for all age groups was 16.7 weeks. However, it was 21.5 weeks for persons 45 to 54, 23.9 weeks for those 55 to 64, and 24.9 (almost 6 months) for individuals 65 or older.

MEAN DURATION OF UNEMPLOYMENT, BY AGE AND SEX

[In weeks]

Age/sex	IV–1973	I–1975	I–1976
Male:			
45 to 54	15.1	14.2	22.9
55 to 64	16.7	15.6	23.8
65 plus	13.9	17.5	25.1
All ages	10.7	12.3	17.7
Female:			
45 to 54	11.4	13.5	19.6
55 to 64	14.4	14.1	24.1
65 plus	9.2	19.9	24.5
All ages	8.6	10.7	15.3
Both sexes:			
45 to 54	13.1	13.9	21.5
55 to 64	15.3	15.0	23.9
65 plus	12.5	18.3	24.9
All ages	9.7	11.6	16.7

Note: For convenience, the 3 benchmark periods are designated in this table by the specific quarter (in Roman numerals) and year.

Source: Recession's Continuing Victim: The Older Worker, a working paper prepared by the U.S. Senate Special Committee on Aging, July 1976, p. 2.

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Dr. Rosenblum provided this assessment of the employment situation for older workers:

> In the final analysis, an unequivocable conclusion of serious and ongoing economic dislocation is reached. Older workers are playing the game of musical chairs for a share of the Nation's jobs with one leg shackled by weights.
>
> Unless this burden is removed—either by sharply increased aggregate economic activity, specific job creation programs for older workers, or some combination of both—the trends described above are likely to continue.
>
> In a sluggish, high-unemployment profile, the economic system can obtain a sufficient labor force from its younger components. Given the effects of age-ism, exacerbated by the job shortages of insufficient economic growth, many older persons may face the specter of hardship and deprivation in their later years.[7]

In a joint preface, Senators Church, Randolph, and Williams declared that our Nation has failed to develop a comprehensive policy to provide adequate job opportunities for middle-aged and older workers. They added:

> This deficiency should be cause for serious concern among policymakers. No nation can achieve its full potential if large numbers of its most experienced and productive citizens are banished to the sidelines.[8]

In fiscal 1976, persons 45 or older represented only 7.2 percent of all enrollees in Department of Labor manpower programs. Yet, they accounted for 19 percent of the total unemployment in October 1976. Individuals 55 or older represented only 2.9 percent of all enrollees in work and training programs, but accounted for 8 percent of unemployment in October 1976.

ENROLLMENT OF MIDDLE-AGED AND OLDER PERSONS IN DEPARTMENT OF LABOR MANPOWER PROGRAMS, FISCAL YEAR 1976 [1]

Program	Total number	Persons aged 45 to 54		Persons aged 55 to 64		Persons aged 65 or older	
		Number	Percent	Number	Percent	Number	Percent
Comprehensive Employment and Training Act (CETA)	2,482,400	133,200	5.4	65,600	2.6	19,600	0.8
Title I—Manpower services	(1,731,500)	(69,300)	(4.0)	(34,600)	(2.0)	(13,800)	(.8)
Title II—Public service jobs	(255,700)	(20,300)	(7.9)	(9,700)	(3.8)	(1,800)	(.7)
Title VI—Emergency jobs	(495,200)	(43,600)	(8.8)	(21,300)	(4.3)	(4,000)	(.8)
Work Incentive (WIN) entered employment	186,062	13,257	7.1	1,658	0.9	376	.2
Jobs Corps (all under 22)	41,000						
Summer youth program (all under 22)	[2] 720,000						
Senior community service employment program	13,300			5,812	43.7	7,488	56.3
Total	3,442,762	146,457	4.3	73,070	2.1	27,464	.8

[1] The Public Works and Economic Development Act (administered by the Department of Commerce) provides another potentially important source for employment—particularly the title X job opportunities program. For further discussion, see p. 91.
[2] Estimated figure.

[7] Pages 16 and 17 of working paper cited in footnote 2.
[8] Page iii of working paper cited in footnote 2.

The Rosenblum working paper called for several actions to maximize job opportunities for middle-aged and older workers, including:

—The 65-year ceiling for the Age Discrimination in Employment Act should be eliminated.

—The title VI emergency public service jobs program should be continued and amended to require prime sponsors to provide alternative working arrangements for older Americans.

—Funding for the title IX Older American Community Service Employment Act should be increased to at least $90.6 million.

—The Department of Labor should initiate affirmative actions to assure that persons 45 or older are more appropriately represented in title I (manpower services) and title II (public service employment for areas with an unemployment rate of at least 6.5 percent for 3 or more consecutive months) of the Comprehensive Employment and Training Act.

—A special commission should be established to improve and refine data gathering efforts about unemployed middle-aged and older workers.

II. THE LEGISLATIVE VICTORIES

The 94th Congress took a number of actions resembling Dr. Rosenblum's recommendations before adjournment in October. These actions—if appropriately implemented and funded—can provide increased employment opportunities in 1977 for middle-aged and older workers.

Funding for Title IX Senior Community Service Employment: Congress enacted the title IX Older American Community Service Employment Act[9] in 1973 for the purpose of converting the mainstream pilot projects—such as senior aides, the senior community service employment program, senior community service aides, and green thumb—into permanent, ongoing national programs.

Despite the strong support for title IX, the Nixon and Ford administrations never requested funding. Congress, however, kept the program alive through 11th-hour appropriations and continuing resolutions.

As of June 30, 1976, title IX was operating in every State in the Nation. Enrollee characteristics:

—51 percent were women and 49 percent were men.

—Nearly one-half (49.7 percent) had 8 years of schooling or less. Almost 7 out of 10 (68.9 percent) had 11 years of schooling or less.

—73.2 percent were white, 20.1 percent black, 2.9 percent Indian, and 3.8 percent other races. Of this total, 5.8 percent were Spanish-Americans and were included among whites, blacks, Indians, and other races.

—18.3 percent were aged 55 to 59, 25.4 percent were 60 to 64, 27.7 percent were 65 to 69, 18.5 percent were 70 to 74, and 10.1 percent were 75 or older.

Average wages paid to these economically disadvantaged individuals amounted to $2.42 per hour. More than 62 percent of the

[9] Public Law 93-29, approved May 3, 1973.

title IX services benefited the general community, including education (11.2 percent); health and hospital (3.9 percent); housing and home rehabilitation (1.1 percent); employment assistance (0.9 percent); recreation, parks and forests (15.6 percent); environmental quality (4.8 percent); public works and transportation (6.9 percent); social services (12.4 percent); and other services (5.3 percent). Nearly 38 percent of the services were directed at the elderly and included senior community service employment project administration (3.4 percent); health and home care (3.7 percent); housing and home rehabilitation (3.9 percent); employment assistance (0.8 percent); recreation and senior centers (5.9 percent); nutrition (8.0 percent); transportation (3.4 percent); outreach and referral (6.8 percent); and other services (2.0 percent). During fiscal 1976, the title IX program also provided 1,830 unsubsidized placements for older workers.

Congress responded to the high level of unemployment among older workers in 1976 by providing the highest funding levels in history for the title IX senior community service employment program. Once again, this action was achieved because of strong bipartisan support. Senators Eagleton, Brooke, and Church led the drive for a $55.9 million funding level as an amendment to an Emergency Swine Flu Appropriations bill.[10]

The Senate amendment provided a 21-percent increase in the number of job opportunities under title IX, from 12,400 to 15,000. The $55.9 million funding level—available from July 1, 1976 to June 30, 1977—was allocated as follows:

	Prior		Eagleton-Brooke-Church amendment (July 1, 1976–June 30, 1977)	
	Funding	Positions	Funding	Positions
National Farmers Union	$18,956,000	5,075	$22,676,000	6,070
National Council on the Aging	5,035,000	1,348	6,029,000	1,618
National Council of Senior Citizens	10,473,000	2,804	12,540,000	3,354
National Retired Teachers Association-American Association of Retired Persons	7,646,000	2,047	9,156,000	2,457
U.S. Forest Service	3,874,000	1,038	4,662,000	1,249
Alaska, Delaware, Hawaii	201,000	54	501,000	135
Virgin Islands, Samoa, Guam, Trust Territories of the Pacific Islands	136,000	36	336,000	88
Total	46,321,000	12,402	55,900,000	14,971

Senators Eagleton, Brooke, and Church won another important victory for title IX when the Senate Appropriations Committee adopted their amendment to the fiscal 1977 Labor-HEW Appropriations Act (H.R. 14232) to provide $90.6 million for the senior community service employment program, effective from July 1, 1977, to June 30, 1978. President Ford later vetoed this measure. However, the House (by a vote of 312 to 93) and the Senate (by a vote of 67 to 15) decisively overrode the veto on September 30.

State governments will be allocated $15.234 million under the new appropriations and national contractors will receive $75.366 million.

[10] Public Law 94-266, approved Apr. 15, 1976.

The Eagleton-Brooke-Church amendment will increase enrollment for title IX from 15,000 to 22,600. Of this total, 3,800 positions will be allocated to State governments and 18,800 to national contractors.

Title X Job Opportunities Program: Older workers have also benefited from the title X job opportunities program (Public Works and Economic Development Act). In 1976, nearly 4,800 older Americans were employed in a wide range of capacities, including historical site rehabilitation, environmental aides, parks and recreation aides, home health aides, legal service aides, ombudsmen, home maintenance service workers, day care personnel, social workers, and preretirement counselors. The Administration on Aging received funding under title X from the Economic Development Administration (Department of Commerce) and awarded 16 grants totaling almost $21.9 million to:

Project sponsor	Projects	Job slots	Project sponsor	Projects	Job slots
NRTA/AARP	25	2,500	Indiana Commission on the Aging	3	70
Farmers Union	23	182	New York City Office on Aging	1	1,000
NCOA	5	238	Family Services of Greater Lowell	1	50
NCBA	1	10	Grand Rapids AAA	1	62
Illinois Department on Aging	2	300	North Carolina Office on Aging	1	39
Florida Office on Aging	3	97	South Carolina Office on Aging	1	30
Mississippi Office on Aging	1	56	Virgin Islands Office on Aging	1	20
Wisconsin Division on Aging	1	53	Amigos Del Vallee, Inc., Texas	1	104

Source: Administration on Aging.

Congress approved the Public Works and Economic Development Act Amendments (S. 2228) shortly before adjournment.[11] This legislation (Public Law 94–487)[12] continues the programs under the Public Works and Economic Development Act for 3 years with a $4.9 billion authorization, including the title X job opportunities program. The 1976 amendments made several changes in title X. Funding, for example, is now triggered when the unemployment rate is 7 percent or greater during the preceding calendar quarter. Nearly 65,000 jobs can be provided under the maximum annual authorization of $325 million.

Emergency Jobs Programs Extension Act: In addition, Congress passed an Emergency Job Program Extension Act[13] which provides a 1-year extension (through fiscal 1977) of the title VI Emergency Public Service Jobs program under the Comprehensive Employment and Training Act. Public Law 94–444 also includes a Senate amendment (sponsored by Senators Williams, Kennedy, Randolph, and Nelson) to direct sponsors of employment projects to give special consideration to alternative, working arrangements—including flexible hours, shared time, and part-time jobs—particularly for older persons and parents with young children.

[11] The House and Senate agreed to the conference report on S. 2228 on Sept. 30, 1976.
[12] Approved Oct. 12, 1976.
[13] Public Law 94–444, approved Oct. 1, 1976.

FINDINGS AND RECOMMENDATIONS

Middle-aged and older workers have been especially hard-hit by the 1974–75 recession. In some respects, persons 45 or older are worse off in 1976 than they were at the height of the recession.

Throughout 1976, unemployment has hovered in the 1.3 to 1.4 million range for middle-aged and older Americans. Once unemployed, these workers run a great risk of being without work for a long period of time.

Several immediate and long-range actions are needed to develop an effective national employment policy for middle-aged and older workers. The committee recommends that the following steps be adopted as soon as possible:

—Funding for the title IX program should be increased in 1977 to provide additional job opportunities for low-income persons aged 55 or older.[14]

—Funding should be provided to continue the title X job opportunities program.[15]

—The Department of Labor should take early action to implement the Williams-Kennedy-Randolph-Nelson amendment to the emergency jobs program extension act.

—The age-65 ceiling for the Age Discrimination in Employment Act should be removed.[16]

—Funding for the Age Discrimination in Employment Act should be increased to permit vigorous enforcement of the law.

—The Department of Labor should encourage CETA (Comprehensive Employment and Training Act) prime sponsors to take steps to assure that middle-aged and older workers are appropriately represented in work and training programs.

—Legislation to designate the second full week in March as "National Employ the Older Worker Week" should be enacted into law.[17]

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[14] The Fiscal 1977 Economic Stimulus Appropriations Bill (H.R. 4876)—as approved by the House on March 15, 1977—would provide a $150 million funding level for title IX, the full authorized amount.

[15] H.R. 4876 (the Fiscal 1977 Economic Stimulus Appropriations bill) would also direct the Secretary of Labor to use $10.5 million of discretionary funds under the Comprehensive Employment and Training Act to continue the 71 older worker projects funded by the Administration on Aging under title X Job Opportunities program of the Public Works and Economic Development Act.

[16] On Feb. 27, 1975, Senator Fong introduced S. 871, which would amend the Age Discrimination in Employment Act to remove the age 65 limitation. Senator Domenici reintroduced this bill (now S. 481) on January 28, 1977—after Senator Fong retired from the Senate.

[17] Public Law 94–275 authorizes the President to designate the second week beginning Mar. 13, 1977, as "National Employ the Older Worker Week." However, it will be necessary to enact legislation each year to continue this practice.

CHAPTER VII

TRANSPORTATION: CONTRADICTIONS IN STRATEGY

In the second half of 1976 new Federal regulations and initiatives in various communities advanced the goal of better transportation for older Americans. However, information indicating continued delays in the implementation of section 16(b)(2)[1] elderly handicapped transit programs was brought to the attention of the Committee on Aging. And the Department of Transportation's new bus purchase guidelines triggered a pair of major lawsuits, the outcome of which will determine the design characteristics of America's bus fleet for years to come.

I. THE ADMINISTRATION ON AGING

The Administration on Aging (AoA) demonstrated its commitment to better transportation for the elderly in several ways:

—It issued draft program instructions prescribing the policies which will govern the implementation of the 1975 amendments to the Older Americans Act. Those amendments designated transportation as a title III priority service. Draft regulations governing the signing of comprehensive transportation agreements by State agencies on aging were issued simultaneously.[2]

—AoA held a series of nationwide workshops, cosponsored by the Rehabilitation Services Administration and the Department of Transportation (DOT), which provided data to and promoted cooperation among current providers of transportation for the elderly.[3]

—AoA assisted in the selection of communities eligible for grants under the Office of Human Development's (OHD) transportation initiative project.[4]

—AoA updated its report on state-of-the-art developments in special transportation services.[5]

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[1] See section III, below, for additional information about section 16(b)(2).

[2] AOA–IM (Information Memorandum) 76–62, May 3, 1976, attachments A and C.

[3] AOA–IM–76–81, Aug. 13, 1976.

[4] AOA–IM–77–13, Nov. 17, 1976. The transportation initiative is a 2-year demonstration project which will seek to evaluate the monetary and service quality benefits of multiagency coordinated transportation services. OHD is the lead agency for the initiative; AoA is one of the other four participating HEW units, and the Urban Mass Transit Administration is the final member of this steering committee. HEW's 10 regional offices received 150 preliminary applications. Of those, 28 were forwarded to Washington. The steering committee submitted the 10 applications it considered best to the Office of the Assistant Secretary, who will announce the names of the 5 finalists on Apr. 3, 1977. All 10 of the semifinal applicant groups include agencies which are AoA grantees. (Conversation with Michael Albarelli, Special Assistant to the Director, OHD, Feb. 14, 1977.)

[5] "Transportation for Older Americans—1976—Progress, Prospects, and Potentials"; prepared by the Institute of Public Administration for the Administration on Aging under grant No. 93–P–57405/3–03, November 1976.

II. UMTA RESISTANCE TO S. 662

The House of Representatives failed to pass S. 662, Senator Harrison Williams' amendments to the Urban Mass Transportation Act (UMTA) of 1964. This bill would permit the $500 million available for rural transportation to be used for operating as well as capital expenses. The failure of this bill to be reported out of committee may be attributable to President Ford's threat to veto it unless urban locales were barred from using UMTA funds for operating expenses.[6] This would place America's cities under the same fiscal constraints which transit spokesmen in many rural areas currently object to. Previously, UMTA had also declared that it did not favor another provision of S. 662 which would guarantee the participation of elderly and handicapped individuals on mandatory local and national transportation advisory boards.[7]

Rural Needs

The importance of transportation to elderly residents of rural areas was emphasized by Senator Dick Clark during field hearings in August 1976:

> . . . It does not really matter much what the Federal, State, or local government provides if it is not accessible to anybody.
>
> . . . Transportation is really a key to the problem of rural services. . . . And yet, we are told by experts that even though rural areas depend more on an effective transportation system than urban areas, rural residents are losing access to any kind of system faster than other areas.[8]

And, in a hearing statement submitted by the transportation coordinator for Iowa's Area XV Agency on Aging, the desire for Federal operating assistance was reemphasized:

> . . . In many grant applications the emphasis is on capital outlays, rather than operating expenses. In rural Iowa as well as other places, the strain of operating a system cannot be met by local support totally.[9]

III. CONTINUED DELAYS IN THE SECTION 16(b)(2) PROGRAM

Committee on Aging hearings in 1975 had revealed a lack of coordination and initiative on the part of DoT in implementing the section 16(b)(2) program, which provides grants to private, nonprofit groups for the provision of special transportation for the elderly and handicapped.[10] During visits by Committee on Aging staff to the New York

[6] A letter stating the President's intent to probably veto unless this condition was met was sent by Secretary of Transportation Coleman and read to members of the House Subcommittee on Surface Transportation by ranking Republican E. G. Shuster on July 20, 1976, during an open markup session.

[7] Testimony of Robert E. Patricelli, Administrator, UMTA, before the House Subcommittee on Surface Transportation, June 2, 1976.

[8] "The Nation's Rural Elderly," hearing before the Special Committee on Aging, U.S. Senate, Ottumwa, Iowa, Aug. 16, 1976, p. 6.

[9] *Ibid.*, p. 33, statement of Pam Hunt.

[10] See Developments in Aging: 1975 and January–May 1976, pp. 128–30.

City area in the summer of 1976, reports were received that serious delays were persisting in New York State. It was specifically alleged that long delays in vehicle delivery, poor communications, and paperwork burdens were causing enthusiasm for the program to wane in sponsoring communities.

Committee on Agi g Chairman Frank Church, disturbed by these reports, directed a letter of inquiry to New York State Transportation Commissioner Raymond T. Schuler. In his reply, the commissioner stated:

> . . . The most important reason for the delay between grant approval and placement of vehicle orders was UMTA's requirement of central purchasing at the State level.[11]

UMTA first made this requirement known 9 months after the initial announcement of the program. Mr. Schuler stated that the policy not only increased delays and costs but conflicted with a New York constitutional ban. After intensive legal research, New York set up an elaborate system of escrow accounts so it could undertake such purchases for the participating private agencies. UMTA is still requiring New York to continue this practice of central purchasing.

Mr. Schuler also attributed delays to the inability of the sponsoring agencies to deal with UMTA's elaborate grant request form. He noted that this form has been made more demanding in the program's second year of operation.

Mr. Schuler concludes: ". . . The time has certainly come for a serious reevaluation of this program."

He further suggests that Congress and UMTA should reconsider the basic premises underlying the 16(b)(2) program.

As of February 1977, UMTA still did not have a formal monitoring system established for the 16(b)(2) program. Instead, it continues to rely on the semiannual progress reports submitted by participating agencies. UMTA's official stance is that the program has not been in operation a sufficient time to permit comprehensive evaluation. However, in September 1976 it did contract for a preliminary analysis by a private consultant; that report will be available in mid-1977.[12]

IV. RETREAT ON TRANSBUS

The 1970 Biaggi amendment to the Urban Mass Transit Act states:

> It is hereby declared to be the national policy that elderly and handicapped persons have the same right as other persons to utilize mass transit facilities and services; that special efforts shall be made in the planning and design of mass transportation facilities so that the availability to elderly and handicapped persons of mass transportation which they can effectively utilize will be assured; and that all Federal programs offering assistance in the field of mass transportation (including the programs under this chapter) should contain provisions for implementing this policy.[13]

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[11] Senator Church's letter to Commissioner Schuler, dated July 12, 1976, and the Commissioner's reply, dated Aug. 31, 1976, are reprinted in part 2, appendix 5, of this report.
[12] Conversation with Debbie Kimack, Congressional Liaison Assistant, DOT, Feb. 17, 1977.
[13] 49 U.S.C. 1612(a).

Similar language appeared in the Federal Highway Act Amendments of 1974 and in DOT's fiscal 1975 appropriations legislation.

In response to this policy directive, DOT initiated in 1971 a 5-year, $27 million program of grants to three manufacturers [14] in order to develop a modern generation of safer, more accessible, and attractive buses and to stimulate competition in this industry.

A 1975 consultant's report, prepared at DOT's request, surveyed the program's results and found:

—The technology necessary for an advanced "TRANSBUS" vehicle was available.

—Its production price would exceed that of present buses by 12.5 percent, but passenger gains of up to 10 percent and insurance and accident cost savings of up to 20 percent could be expected.

—Only the TRANSBUS could have a significant impact on the overall comfort and safety of the elderly.[15]

UMTA held public hearings on the issue of bus specifications in Washington on May 5, 1976. Testimony was mixed. General Motors opposed TRANSBUS while American Motors and Rohr Flxible spoke in its favor; the American Public Transit Association stated its opposition to mandatory TRANSBUS usage but the Southern California Rapid Transit District reported that no manufacturer had elected to bid on its desired purchase of 200 full-access buses.

At the end of July UMTA issued its new full-size bus design policy.[16] Under it, buses purchased with Federal aid [17] after February 15, 1977 must:

—Have front steps not exceeding 8 inches in height, and offer a wheelchair lift as an option.

—Have an "effective," or lowest front-end height of 24 inches, achieved through use of a hydraulic kneeling device to lower the bus from its normal 29-inch height.[18]

This retreat from TRANSBUS' design specification has not gone unchallenged. In anticipation of UMTA's policy, the Public Interest Law Center of Philadelphia (PILCOP) filed a class action suit against DOT, UMTA, and the Federal Highway Administration.[19] The suit seeks to compel DOT to require that Federal funds be used only for the purchase of accessible buses. In their brief, plaintiffs argue:

> The low floor, wide door, ramped TRANSBUS is the only technologically proven design which will assure mobile disabled and elderly persons ready access to and effective use of public transportation. Such accessible vehicles will not be provided and put into operation unless defendants require TRANSBUS as the standard bus design for public transit

[14] The three grantees were General Motors, American Motors, and Rohr Flxible.

[15] Impact of TRANSBUS on U.S. Transit Systems, prepared by Booz, Allen, Applied Research and Simpson & Curtin for UMTA. TRANSBUS document 75-002 (draft).

[16] DOT News Release, UMTA 76-62, July 27, 1976.

[17] Virtually all public transit buses in the United States are now purchased with Federal assistance.

[18] TRANSBUS has a 22-inch height and thus does not require a kneeling device. It has a single 6-inch step. The lower floor height allows a built-in, low-cost ramp at the front door; such a ramp can be utilized by all passengers and, unlike a wheelchair lift, would be a normal maintenance item.

[19] Additional plaintiffs include the National Council of Senior Citizens, the National Caucus of the Black Aged, and the Pennsylvania Association of Older Persons.

> operating agencies purchasing buses with Federal financial assistance. . . . defendants have adopted policies, promulgated regulations, and engaged in practices which perpetuate major physical and structural barriers in the design of transit equipment, which exclude mobile disabled and elderly people from effective utilization of public transportation, which preclude the production of an accessible, full-size bus, and which confine mobile disabled and elderly people to prohibitively expensive, segregated transportation facilities.[20]

In October the Court denied summary judgment to DOT and denied the request for a protective order which would have barred plantiffs' access to UMTA files. The case then proceeded to the discovery stage.[21]

On August 30, 1976, American Motors (AMC) obtained an injunction barring UMTA from awarding funds to Houston and other cities for the purchase of General Motors' "intermediate" RTS–2 bus.[22] The AMC suit contends that UMTA's policy is illegally exclusionary and discriminatory and will return the field of bus manufacture to a state of monopoly.[23] Unless this suit is quickly settled all bus production in the United States will have to cease for lack of new orders in early 1977;[24] UMTA is attempting to avoid a shutdown by expediting orders for buses of current design while considering a revision of the policy issued in July.[25]

Allegations of insincerity and collusion have been made in both suits. PILCOP has introduced a memorandum from UMTA's Chief Counsel stating that "the [proposed TRANSBUS] regulations were developed for litigation and political reasons, and say what they must say in order to satisfy those concerns."[26] American Motors has submitted as evidence an internal UMTA memo dated October 25, 1975. It recounts a meeting between "top officials from GMC" and then-UMTA Administrator Herringer. Followup phone conversations informed the UMTA Administrator that GMC's board of directors had decided to invest $36 million in their new bus family, and that the investment had later reached $50 million. The memo then states: "I believe Mr. Herringer's position was that the grantees could sole source the new bus if a new and comparable bus was not available".

On the basis of this document and other evidence, AMC alleges:

> Throughout the period of time during which UMTA was *privately* declaring to GM that its development of the RTS–2 could be amortized by means of sole source, federally financed procurements, UMTA was *publicly* declaring its intention (1) to maintain competition within the transit bus market and (2) to require recipients of Federal mass transit funds to

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[20] *Disabled in Action of Pennsylvania, et al* v. *William T. Coleman, Jr., et al*, complaint, filed in the U.S. District Court for the Eastern District of Pennsylvania, June 17, 1976.

[21] Conversation with James Raggio, Attorney, PILCOP, Nov. 22, 1976.

[22] The RTS–2 is an upgraded standard bus with some mechanical and appearance alterations. It meets UMTA's new design specifications. Rohr Flxible is capable of producing a similar vehicle. But AMC claims that its reliance on UMTA's declared intent to mandate TRANSBUS has left it unprepared to produce an interim vehicle.

[23] General Motors still produces the engines used by all three manufacturers.

[24] Washington Post, Nov. 3, 1976.

[25] New York Times, Nov. 10, 1976.

[26] *Disabled in Action of Pennsylvania, et al* v. *William T. Coleman, et al*, memorandum in response to defendants' motion to dismiss, Oct. 27, 1976, p. 77.

procure low-floor competitively produced TRANSBUS vehicles.[27]

While the future direction of the TRANSBUS program and UMTA's bus regulations is unclear at this time, it seems that a combination of administrative review, judicial action, and congressional inquiry may clear up current confusion during 1977.[28]

V. UMTA'S PARATRANSIT POLICY

In October, UMTA issued its proposed policy in regard to paratransit services.[29] "Paratransit" generally refers to flexible, coordinated transportation services utilizing small to intermediate size vehicles. Providers may include social service agencies, churches, transit authorities, and taxi companies.

UMTA declared that it would seek to insure that the provision of such services had been considered in all the plans it reviews, including those relating specifically to the elderly and handicapped (such as the section 16(b)(2) program). However, UMTA will leave the ultimate determination of service and vehicle mixtures to local judgment. And UMTA will not provide financial assistance to any public or private nonprofit paratransit operation which will compete with existing paratransit services, unless the local transportation plan provides for the "maximum feasible participation" of private transit companies. To meet that condition, the plan must offer private providers, such as taxi companies, the opportunity to bid to provide new paratransit services; and the provider must be selected on the basis of cost efficiency and effectiveness.

UMTA's protection of existing private operators is an internal policy not required by law.[30] Private providers may be able to offer quality service at low cost. However, to do so will probably require new rate structures permitting multiple vehicle occupancy, and the surmounting of the administrative and auditing difficulties which have developed in prior attempts at taxi subsidization.[31]

Paratransit services tend to be more costly than full-size bus services because a larger number of smaller vehicles require more drivers and maintenance.

The Transbus lawsuits (see section IV of this chapter) will probably determine the extent if any to which "separate but equal" paratransit services may substitute for full-size buses accessible to the elderly and handicapped.

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[27] *AM General Corporation* v. *Department of Transportation, et al.* Plaintiff's proposed findings of fact and conclusions of law, filed in the U.S. District Court for the District of Columbia, Oct. 1, 1976, pp. 40–41.

[28] On Sept. 16, 1976, Senator Edward Kennedy decried the lack of competition in the bus industry and inserted in the Congressional Record an article detailing the Stanford Research Institute's assertion that pressure from General Motors shaped UMTA's policy. Congressional Record, pp. S 15963–5.

The General Accounting Office, at the request of Representative John Moss, is preparing a report on UMTA's policies toward section 16 of UMT Act, including TRANSBUS. Congressman Moss will receive the report in March 1977; no public release date has yet been set. (Conversation with Patricia Lynch, Legislative Assistant to Representative Moss, Feb. 17, 1977.)

[29] Federal Register, vol. 41, No. 204, Oct. 20, 1976, pp. 46412–3.

[30] Conversation with source cited in footnote 12, Dec. 13, 1976.

[31] For a discussion of the history and difficulties of taxi subsidization, see "Transportation for the Elderly: The State of the Art," DHEW publication No. (OHD) 75–20081, January 1975, pp. 27–43. This volume was prepared jointly for the Administration on Aging and the Office of Human Development.

The Taxi Project

Aside from cost, the other principal barrier to the use of taxis by the elderly and handicapped has been vehicle design. In an effort to apply modern design techniques to the taxi, the Museum of Modern Art featured an exhibit called "The Taxi Project: Realistic Solutions for Today" from June 18 to September 7, 1976.[32] The object was to produce a vehicle that combined effective space utilization, accessibility without any need for driver assistance, and stringent emission standards. Five prototype vehicles meeting these criteria were exhibited.[33] All of them had built-in ramps for accommodating wheelchairs; several were capable of being stretched into 10-passenger buses.

The Taxi project demonstrated that considerable room for design improvement exists for this important segment of our national transit system, carrying 40 percent more passengers than all U.S. rapid transit combined.[34] Federal standards could, of course, mandate such design improvements for paratransit services receiving Federal assistance.

VI. LOCAL PROGRAMS

A number of developments during 1976 demonstrated that a commitment to better transit for the elderly is taking hold in some areas. Here are some of the more significant:

—On New York City's Lower East Side, an area noted for high crime and poor public transit service, the Vera Transportation Project has initiated door-to-door service. With legal assistance from the Vera Institute of Justice, the project has successfully combined UMTA and AoA funding. Project drivers are ex-addicts supplied by Wildcat Service Corp., a nonprofit organization receiving some funding from the Department of Labor.[35] Each driver underwent training in the proper techniques of assisting the handicapped at the Rusk Institute of Rehabilitative Medicine.

Vera expected to have its complete vehicle fleet assembled by January 1977. Its major problem to date has been that of obtaining insurance coverage. This obstacle is a common one for nonprofit paratransit operations, complicated in this case by the drivers' past criminality. Vera is attempting to make arrangements with the Social Security Administration for the transport of medicaid patients. Private invalid coaches in New York City charge $28 per round trip for such service; Vera officials estimate they could do the same job for $5.

Committee on Aging staff visited the Vera Project and rode its vehicles in the summer of 1976, and reported high standards of performance by all Vera staff, and enthusiasm of community residents utilizing the service.

—UMTA announced that it will solicit bids for design strategies aimed at the elimination of architectural barriers in the Nation's subways.[36]

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[32] The exhibit was sponsored through grants from UMTA and Mobil Oil.

[33] The exhibiting manufacturers were American Machine & Foundry, Steam Power Systems, Volvo, Volkswagen, and Alfa Romeo. The major Detroit manufacturers declined to submit vehicles.

[34] "The Taxi Project," exhibit catalog, the Museum of Modern Art, 11 W. 53 St., New York, N.Y. 10019, p. 107.

[35] As of May 1976, Wildcat employed 1,300 exoffenders and addicts in a variety of public service jobs, including a meals-on-wheels project in Manhattan.

[36] "Report of the National Center for a Barrier Free Environment," vol. 2, No. 6, November-December 1976, p. 2.

—Mayor Abraham Beame of New York announced the formation of a task force to plan transportation services for the elderly and handicapped. The Consolidated Edison Co. was to assist this program through inclusion of a questionnaire in its December bill designed to assess community needs.[37]

—An accessibility guide to 118 airports in America and abroad was released through the cooperative efforts of the Airport operators Council International and the Architectural and Transportation Barriers Compliance Board. It covers 71 features such as ramps and reserved parking, and establishes the air transport industry as the first segment of public transportation to publish such information.[38]

—Mini- and medium-size buses may be on the way to becoming integral parts of the "feeder" system for Washington's new Metro subway. Such services will increase the ability of the elderly to utilize the subway.

The Council of Montgomery County, Md., is contemplating the purchase of 40 small buses. The county estimates that such service would add only 3 percent ($300,000) to its annual transit subsidy budget, but could provide flexible service for and additional, 1.5 million passengers yearly between their residential neighborhoods and the subway in downtown Silver Spring.[39]

Metro's new general manager, Theodore C. Lutz, is considering offering a mix of vehicle types to feed the subway's downtown stations. Metro's 2,000-bus fleet would be augmented by 50 articulated (extra long, large capacity) buses for use on heavy volume routes, and by small buses traveling circular neighborhood routes. These small vehicles will facilitate subway use by elderly persons living out of walking distance from stations.[40]

—Transportation services being developed in the rural midwest were explored during the summer 1976 Committee on Aging field hearings. Senator Dick Clark conducted a portion of one hearing on an RSVP minibus traveling between Sioux Falls, Iowa, and Canton, S. Dak.[41] The committee plans to continue its investigation of rural transportation problems and programs in 1977.[42]

—The U.S. Conference of Mayors issued "Serving the Urban Elderly": one chapter of this volume describes how free fares, paratransit services, special vehicles, and routing improvements are making transit more suitable for the elderly in communities as diverse as Los Angeles, Calif., and Gainesville, Ga.[43] The current scheme of Federal assistance is also outlined.

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[37] New York Times, Dec. 10, 1976.

[38] New York Times, Dec. 10, 1976. The guide, "Access Travel: A Guide to Accessibility of Airport Terminals," is available from the Airport Operators Council International, 1700 K St., NW., Washington, D.C. 20006.

[39] Washington Post, Dec. 9, 1976, p. A 48.

[40] Washington Post, Dec. 11, 1976. The Metro subway is barrier-free. Transit service and routing is generally geared to the needs of employed commuters rather than retirees and other persons needing intraneighborhood service.

[41] "The Nation's Rural Elderly," part 5. Hearing not printed at this time.

[42] Final applications for the section 147 rural highway public transportation project were awarded as of July 21, 1976. This program awarded grants to public and private nonprofit agencies for 2-year model projects designed to develop and improve public transit use in rural America. The Federal Highway Administration has not yet begun to evaluate the results of these projects, and has no recommendation as to whether new funds should be committed to it. (Conversation with Joanne Thornton, Liaison Assistant, Federal Highway Administration., Feb. 17, 1977.)

[43] "Serving the Urban Elderly: Strategies for Mayors," issued by the Task Force on Aging, U.S. Conference of Mayors, 1620 Eye Street NW., Washington, D.C. 20006, August 1976, pp. 15–86.

FINDINGS AND CONCLUSIONS

The cause of improved transportation for the elderly made gains and suffered setbacks in the second half of 1976. Discouraging aspects included the failure to fund the operating expenses of rural public transit, continued delays in implementation and questionable premises of the section 16(b)(2) program, and UMTA's retreat from the TRANSBUS standards. However, AoA's positive activities, along with a growing national awareness of this problem and the expectation that a new Presidential administration will provide fresh viewpoints, provide hope for greater progress in 1977.

The establishment of a transit system which meets the needs of older Americans may well develop out of the increasing recognition that the days of cheap minerals and energy, and hence cheap individual transportation, have been left behind. Today, America's primary transportation system remains the private automobile. Because of that, the elderly continue to experience a transportation "double jeopardy," that is, the same physical and economic barriers to continued auto ownership also prevent them from utilizing inadequate, inaccessible, and expensive public transit. As auto ownership becomes an economic hardship for greater numbers of Americans, due to the rising prices of both the vehicles and their fuels, the ranks of the transportation disadvantaged will grow. And with it will grow the public's wish for improved public transit services.

It will then be seen that the service and design improvements which are essential for the use of public transit by older Americans also translate into more attractive, more accessible, and safer transit for all Americans.

CHAPTER VIII

STEPS TOWARD AN AGING RESEARCH AND TRAINING STRATEGY

Research in the field of aging has been redirected from a narrow view of aging as a degenerative process to a broader focus upon the physiological, biological, medical, behavioral, social, cultural, and economic characteristics of the aging process. To conduct and support biomedical, social, and behavioral research and training in the field of aging, the Congress created a National Institute on Aging.[1] The Institute, which is housed within the National Institutes of Health (NIH), was established in October 1974. Its work, coordinated with other agencies' efforts, is leading toward the development of a national aging research and training strategy.

I. NIA: PRESENT AND FUTURE

The National Institute on Aging (NIA) supports both intramural and extramural research in aging. The intramural program, housed at the Gerontology Research Center in Baltimore, Md., is divided into the Laboratory of Behavioral Sciences, the Clinical Physiology Branch, the Laboratory of Cellular and Comparative Physiology, and the Laboratory of Molecular Aging. The Gerontology Research Center supports the so-called Baltimore longitudinal study of aging, the renowned longitudinal monitoring of Baltimore male residents as to cardiac, renal, and pulmonary function; body composition; exercise physiology; carbohydrate and lipid metabolism; drug pharmacokinetics; nutrition and endocrine factors; and behavioral and social variables.

The NIA extramural research program supports efforts in the biological, medical, psychological, and social aspects of aging. The extramural grants are awarded in the areas of cellular aging, endocrine change with age, immunologic aging, the use of experimental animals in aging research, cognitive change with age, and societal aspects of aging. Extramural grants are awarded to established research centers and individual investigators upon application to the NIH.

A. NIA Progress in 1976

The National Institute on Aging supported about 150 research grants during fiscal year 1976 on a budget of approximately $17.5 million.[2] The Institute awarded about 51 percent of its grants to estab-

[1] Public Law 93-296, the Research on Aging Act, was signed into law on May 31, 1974, and created the National Institute on Aging.

[2] The Institute received an additional $4,038,000 in appropriations for the transitional quarter of fiscal year 1976—June 30 through Sept. 30, 1976.

lished research centers and 49 percent to individual investigators. These grants were concentrated in the areas of biological research (80 percent), social and behavioral research (16 percent), and investigative medicine (4 percent). Examples of the variety of proposals approved and supported by the NIA include:

—Damage, repair, and survival in aging cells;
—Age differences in adult memory;
—The uses of the past in adult development and aging;
—Age and timing of nutrition intake and wheel activity;
—Neuroendocrinology of senescence.

The NIA was given a substantial increase in support for fiscal year 1977 when the Congress raised its funding to $30 million. This was $3.8 million above the administration's budget request of $26.22 million for the NIA in fiscal year 1977. NIA estimates that this increased funding will support between 230 and 250 grants during fiscal year 1977 as opposed to the 15[illegible] supported in 1976.

NIA is also mandated to support fellowships and some forms of training. During fiscal year 1976, the Institute supported 105 trainee training grants, fellowships, and the National Research Service Award (pre- and post-doctoral fellowships made to young scientists to carry out the type of research that the NIA supports). This training, however, can be directed only toward the conduct of research.

NIA Director Dr. Robert Butler recently described the significance of this limitation:

> It should be clarified that the National Institute on Aging cannot train for the purpose of service. We are only permitted by legislative authority and mandate to train for research. Certainly research nursing, research for medical social work, research for any of the variety of health professions, and scientific professions is perfectly welcome. People can submit proposals toward that end. Unless the law changes, we cannot train.[3]

At present, only 100 scientists are being supported by NIA, and only about 25 complete training each year. NIA staff estimate that for a more adequate development of the many areas which the NIA must oversee and direct, a more "rapid production" of scientists and physicians concerned with aging is necessary.[4]

B. Future Directions

NIA is mandated not only to conduct and support research relating to the aging process, but also to lead other efforts in aging research toward a comprehensive research program. This mandate also requires the Secretary of HEW, in consultation with the NIA and the Advisory Council on Aging, to "develop a plan for a research program on aging designed to coordinate and promote research into biological, medical, psychological, social, educational, and economic aspects of aging" (Public Law 93–296). This plan was submitted to the President, President of the Senate, and Speaker of the House

[3] Testimony by Robert N. Butler, M.D., Director of the National Institute on Aging, before the U.S. Senate Committee on Aging, "Medicine and Aging: An Assessment of Opportunities and Neglect," New York, N.Y., Oct. 13, 1976.
[4] Included in a NIA staff paper, "NIA Training Needs," prepared for the National Advisory Council on Aging, June 1976.

in December 1976 and will assist in directing the NIA and other agencies in a comprehensive aging research program.

Dr. Butler has said:

> The NIA alone should not be expected to meet the many research objectives to be outlined in the DHEW research plan on aging as developed by the National Advisory Council on Aging and the staff of the NIA. If the private sector were to mistakenly assume that the Federal Government's commitment to research on aging embodied in the NIA is sufficient and, therefore, turn their interests elsewhere, the field of aging would suffer greatly. The Institute's efforts must be supplemented by the private sector—the universities, research centers, individual philanthropic foundations, the voluntary organizations in labor, labor unions, and industry (insurance and nursing home in particular), all of whom have a stake in the hoped-for change in character of the later years and the expected benefits of research on aging.[5]

This philosophy will largely reflect the directions of research and study that the NIA will follow. In testimonies, speeches, and discussions throughout the year, Dr. Butler has highlighted several plans for the NIA. The Institute has taken steps toward a reevaluation of all ongoing longitudinal studies in this country. Such studies include the Framingham, Mass., study of 5,209 residents begun in 1949 (1,529 subjects have died) focusing upon the cardiovascular histories of each individual over the 28-year period; the Naval Aerospace Medical Institute study in which 1,000 aviators have been under examination since 1940 for physical, mental, psychological and, ultimately, performance aspects; and the Duke longitudinal medical studies of elderly patients within the Duke University Medical Center—one study begun in 1955 with 267 participants aged 60 through 94 and another integrated investigation initiated in 1968 with 502 participants ranging from age 45 to 69.

The Institute also plans on developing a comprehensive public education program which will disseminate informative materials to both researchers and the aging.

Efforts will be made to develop a working agreement with the Fogarty International Center in order that scholars, visiting fellows, and directors of institutes similar to the NIA from all over the world can meet together to share knowledge and experiences about aging on an international basis.

The lifestyles and different life expectancies of ethnic and racial minorities will be an area in which the Institute will concentrate and perhaps develop a data study.

The NIA has expectations to expand their molecular and cellular aging and immunobiology areas and possibly bring in sections on pharmacology, neurobiology, and cerebral physiology.

The NIA is considering the creation of an emeritus professor and senior associates programs within the Institute.

Plans are being made to develop an interfacing with other Institutes

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[5] Guest editorial: "Early Directions for the National Institute on Aging," by Robert N. Butler, M.D., The Gerontologist, vol. 16, No. 4, 1976. For additional discussion of the research plan and related issues, see report by NIA, part 2, appendix 3, item 4.

under NIH, including a joint symposium with the National Institute of Neurological Disease and Stroke. In addition, an Interagency Advisory Committee for Research on Aging has been formed.[6]

Dissemination of information on pharmacological relationships to the older person will be produced by the Institute. It is hoped that practical information showing, in Dr. Butler's terms, the "drug-drug" (drug overuse, drug-drug interactions, and drug-disease interactions) and "drug-age" interactions for the everyday use of older persons can be produced.

The Institute is proposing to award a contract for a history of the National Institute on Aging. This history would explore the questions of public policy, the origin of the Institute, the problems in securing passage of the statute, and the forces that led to its development.

The Institute will also place emphasis on establishing a concentration on epidemiology of aging. Mental and physical disease will be analyzed.

Efforts will be made to initiate a movement toward more geriatric medicine and training in this country's medical schools. The NIA is planning possible workshops on this and related topics.

C. Interest in Geriatrics as a Specialty

To explore shortcomings of geriatric training within schools of medicine, the Senate Committee on Aging held a hearing at the opening session of the 29th Annual Meeting of the Gerontological Conference in New York City in October 1976. Senator Charles H. Percy opened the hearing by summarizing the results of a survey of medical schools:

> I received 87 replies to my questionnaire [sent to all 114 medical schools in the United States]. Three schools of medicine indicated they had established geriatrics as a specialty in their curricula. They were the University of Health Sciences at the Chicago Medical School, the Arkansas College of Medicine, and the University of North Dakota. Seven schools, including the University of Pittsburgh and Duke University, were viewed by the staff as very close to this goal.
>
> In short, of the 87 schools who answered my inquiry, a total of 10 said they had a specialty in geriatrics or were in the process of doing so. Thirty-five schools said they had programs whereby students or interns worked in nursing homes. Forty-seven schools said they had other programs to serve the elderly, particularly nursing home patients. These programs reportedly ran the gamut from research in gerontology to outpatient clinics or day care centers for the elderly.[7]

The leadoff witness, Robert Butler, Director of the National Institute on Aging, recommended more geriatric training within the medical schools and the medical profession.

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[6] Members include the NIA, the Administration on Aging, the Office of Nursing Home Affairs, the Federal Council on Aging, Office of Policy Development and Planning of HEW Office of Assistant Secretary for Planning and Evaluation/Health, the Medical Services Administration, Office of Research and Statistics, Division of Special Mental Health Program of the National Institute on Mental Health, Bureau of Drugs of the FDA, National Center for Health Services Research and the Bureau of Quality Assurance of the Health Services Administration.

[7] Opening statement by Senator Charles H. Percy, "Medicine and Aging: An Assessment of Opportunities and Neglect," a hearing before the U.S. Senate Committee on Aging, New York, N.Y., Oct. 13, 1976.

He said:

> The real question is not whether geriatric medicine should be a specialty, certified or otherwise; that is essentially proprietary. Rather, the question is: How can we expose every physician to the procedures of primary care which are necessary to deal with older patients just as we have exposed other primary care physicians—pediatricians, family and general practitioners, internists, and gynecologists. The body of knowledge required to care for old people is not just disease-categorical; it is broad in perspective and in keeping with the complex character of human experience—including the multiple physical, personal, and social processes that occur with age.[8]

Dr. Theodore Sherrod, Department of Pharmacology, School of Basic Medical Sciences at the University of Illinois, said that there appears to be a degree of resistance by many members of the medical profession to regard the elderly patient as having medical problems more or less characteristic of that age group.

He added:

> It is true that while many of the diseases are the same—diagnosed by the same techniques and treated in a similar manner as the younger patient—the rate of healing and the responses of medication in the aged may exhibit striking differences. Just as the pediatric age group have medical problems peculiar to infancy and early childhood, the elderly patient is likely to have medical problems more or less characteristic of that age group.[9]

Dr. Robert Berliner, dean of the Yale University School of Medicine, disagreed with the need for separate attention for geriatrics within the medical school curriculum.

He said:

> The diseases that are the causes of illness and death in the aged are the same as those that begin to appear in people in their thirties and forties. There is no distinct group of diseases that occurs exclusively in older people. They have the same diseases as younger adults. The greatest difference is that they have them much more often. Of course it is also clear that the effects of the process of aging modify the way in which the individual responds to the stress of disease. The interaction of aging and illness can hardly escape the attention of any reasonably sentient student of medicine since the aging make up such a large fraction of the population who seek help in our teaching institutions, but I do not believe that this interaction of aging and illness, which is so much a part of everyday medicine, is a matter that requires separate and specialized attention.[10]

Other witnesses expressed pros and cons about the desirability and practicality of having a geriatric specialty within the medical educa-

[8] Testimony presented before the U.S. Senate Special Committee on Aging, "Medicine and Aging: An Assessment of Opportunities and Neglect," Oct. 13, 1976, New York, N.Y.
[9] Reference cited in footnote 8.
[10] Reference cited in footnote 8.

tion curriculum. Dr. Leslie Libow, medical director of the Jewish Institute for Geriatric Care in New York, summarized much of the discussion by saying:

> The issue is not one of "Do we need another specialty called geriatric medicine?" The issue is clearly that there is a group called elderly who need special medical approaches and there are places called medical schools and hospitals that must train young physicians to meet this unmet need.[11]

II. CENTER FOR STUDIES OF MENTAL HEALTH OF THE AGING

Funds allotted to aging research under the National Institute on Mental Health during fiscal year 1976 amounted to only about 0.5 percent of its appropriations (approximately $1.5 million). However, for fiscal year 1977, it is estimated that about 5 percent (approximately $4.2 million) will be directed toward aging research.

In addition to the funds directed toward research throughout NIMH, a Center for Studies of the Mental Health of the Aging was established on August 4, 1975. The Center is a facilitator and coordinator of NIMH's research, training, and service efforts related to aging and mental health.[12]

The Center also proposed to reach beyond NIMH and coordinate activities with the National Institute on Aging, the other institutes within the Alcohol, Drug Abuse, and Mental Health Administration, and the newly established Committee on Mental Health and Illness of the Elderly.

A. Research Objectives

The Center proposes to identify and explore the following:

—The interplay of psychological, social, and biomedical factors as they affect mental health and illness in later life;
—Factors involved in successful adaptation in later life, with attention to prevention;
—Factors involved in the etiology, predisposition, and aggravation of mental disorders in later life;
—The treatment of mental disorders in later life, with attention to techniques, modalities, service structures, and mechanisms of service delivery;
—Attention to the course of normal aging in the middle years and later life; and
—Attention to the course of mental disorders (for example, neurosis, psychosis, personality disorders) with aging.

B. Training and Manpower

Models will be developed with emphasis on interfacing research findings and the analyses of community support systems and the delivery of mental health services to the elderly. Areas of special focus:

[11] Reference cited in footnote 8.
[12] Unlike the National Institutes of Health which supports only training and research, the National Institute on Mental Health supports services, as well as research and training, related to mental health. NIMH was separated from the NIH in 1965 in order that it could function as a service provider.

—Clinical settings, with particular attention to the community mental health clinics;
—Staff concerns, with attention to multidisciplinary and interdisciplinary training, individual and team approaches, the training of professionals, paraprofessionals, and volunteers;
—Diagnosis and assessment along psychosocial and biomedical parameters;
—Treatment of particular problems such as depression, schizophrenia, and organic brain syndrome in later life;
—Use of particular modalities, such as group therapy and pharmacotherapy with the elderly; and
—Structuring of services, such as day treatment, outreach, et cetera.

Organization of mental health services to the elderly will be coordinated with the various types of community mental health clinics. The Center will give attention to:

—Varying staffing patterns (for example, teams of generalists working with all age groups versus teams of specialists with one team focusing on older persons versus combinations of generalists and specialists);
—Age integration of community mental health clinic patients versus age homogeneity, in the traditional outpatient, inpatient, partial hospitalization, and emergency services;
—Urban versus rural catchment areas;
—Poverty area versus nonpoverty area community mental health clinics;
—Minority group populations and other subpopulations (for example, widows, retired persons) within the larger elderly population;
—Specialized services for particular mental problems in later life; and
—The role of prevention and consultation and education services.

In addition, the Center will analyze methods of facilitating mental health services to the elderly. Such factors to be studied will be:

—Innovative outreach methods;
—Mechanisms for financing a program for the elderly at community mental health clinics; and
—Involvement with other community service agencies, care providers, and general resources.

C. Committee on Mental Health and Illness of the Elderly

In July 1975, an amendment to Public Law 94–63 established a Committee on Mental Health and Illness of the Elderly within the Department of Health, Education, and Welfare. The members of this Committee were to be appointed by the Secretary of DHEW and were directed to represent the fields of psychology, psychiatry, social science, social work, and nursing.

This Committee was mandated by the law to make a study and recommendations of:

—The future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of the elderly;
—The appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions; and

—Proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly.[13]

The Committee was commissioned for a 1-year term concluding with the issuance of its final report. However, the late appointments of the Committee made it necessary to extend its legislative authority. Offered by Senator Edmund Muskie—who had sponsored the legislation creating such a Committee—an amendment was enacted to extend the Committee's existence through fiscal year 1977.[14]

The Committee members who will serve on the 1-year appointment are: Mrs. Ruth I. Knee, Fairfax, Va.; Ms. Mary E. Shaughnessy, Director of Ambulatory Care Unit, Tufts New England Medical Center, Boston; Dr. E. Percil Stanford, director, Center on Aging, San Diego State University; Hon. R. Robert Geake, Michigan House of Representatives, Lansing, Mich.; Dr. Wendell M. Swenson, Mayo Medical School, Rochester, Minn.; Dr. James Walker, Bryce Hospital, Tuscaloosa, Ala.; and Hon. James Rupp, mayor of Decatur, Ga.

III. TRAINING AND RESEARCH EFFORTS OF AOA

Closely related to the development of a national strategy in other agencies are training and research programs in the Administration on Aging.

A. Training Grants

For the fourth year in a row, the administration failed in 1976 to request funds for Title IV–A (training under the Older Americans Act) and for the fourth year in a row, the Congress appropriated funds for such training.

In the Labor-HEW appropriations for fiscal year 1976, the Congress provided $10 million for training and an additional $4 million for training for the transitional quarter (June 30 through Sept. 30, 1976). For fiscal year 1977, the Congress appropriated $14.2 million for training. These awards will not be made until early spring of 1977.

The fiscal year 1976 title IV training funds were used to support 100 grants: 64 to colleges and universities for career training; 14 to universities, colleges, and organizations for developmental and quality improvement; 13 to universities and colleges for planning; and 9 to universities and organizations for conferences. According to AoA title IV training funds supported approximately 545 students of the 16,000 enrolled in aging programs throughout the country in 1975. It is estimated that about 600 students were supported with training grants in 1976 among the 16,000 to 20,000 students enrolled in aging classes. Under directions from the Administration on Aging, the title IV–A grantees were given instruction to develop their programs in a manner that would introduce gerontological knowledge into the various disciplines of their institutions. AoA instructed that priority attention be given to introduce such concepts into the following professions:

[13] Public Law 94–63, signed into law on July 29, 1975.
[14] Public Law 94–640, signed into law on Oct. 8, 1976.

—Architecture;
—Communications;
—Counseling (vocational guidance, preretirement);
—Education (educational administration, adult education, elementary and secondary education);
—Industrial design;
—Law;
—Library sciences;
—Nutrition;
—Planning;
—Public administration;
—Recreation; and
—Social work [15]

The colleges and universities receiving title IV career training grants are:

University of Alabama
University of Arizona
University of Arkansas at Little Rock
University of Southern California (3)
Holy Names College
San Diego State University
Adams State College
Colorado State University
University of Connecticut
Federal City College
George Washington University (2)
University of Florida
University of Southern Florida
University of Miami
Albany State
Georgia State
North Georgia College
University of Hawaii (2)
University of Chicago
Wichita State University
University of Kentucky Research Foundation
Southern University
University of Maine
Antioch College
University of Maryland
Boston University (with Brandeis)
University of Michigan
Western Michigan University
Madonna College
Macalester College
University of Minnesota
Kansas City Regional Council for Higher Education
St. Louis University
University of Columbia-Missouri
University of Nebraska

[15] *Informative Memorandum*, AOA-IM-76-53, Mar. 15, 1975, Administration on Aging, DHEW.

Fairleigh Dickinson University
Rutgers University
Syracuse University (2)
Hunter College
New York University
Livingstone College
Wayne Community College
North Dakota Consortium-Minot State College
Miami University
Case Western Reserve
Portland State
University of Oregon
Pennsylvania State University
University of Rhode Island
Fisk University
Bishop College
North Texas State University
Our Lady of the Lake College
University of Utah
University of Washington
University of West Virginia
Parkersburg Community College
University of Wisconsin-Madison
University of Wyoming

In addition to supporting training programs, the title IV training grants are also used to give financial support to students who are in need of financial assistance. These grants can only be given after the student has "exhausted" all other forms of financial aid available to them. As mentioned earlier in this section, title IV grants are expected to support approximately 600 students during fiscal year 1976.

Title IV training funds are also distributed to the States to be used for training activities at the State and local levels. These funds are allocated to the States in accordance to their 60-and-over populations and are to be utilized for "in-service training" and coordination with training under title III (grants to State and community programs on aging) and title VII (nutrition program for the elderly) programs.

The Administration on Aging directs that such training be provided for staffs of State and area agencies, public and private agencies, older persons who desire training to assist in delivery of services to older persons, volunteers, and faculty or administrative personnel of institutions of higher education interested in problems of the older person.

The States must also use at least 50 percent of title IV training moneys for the development and delivery of training programs to serve area agencies on aging. These grants as well as the State training courses may be contracted out to postsecondary education institutions or other public or nonprofit organizations to conduct the actual training. However, the State agency must monitor all such training programs and maintain a staff person who is responsible for the programs and their adherence to the concepts of the Older Americans Act.

B. Research Grants

The Labor-HEW appropriations for fiscal year 1976 included $8 million for AoA research and an additional $2 million for the transitional quarter. Research moneys for fiscal year 1977 were increased by only $500,000. These research grants will be awarded in the early spring of 1977.

Title IV research funds were used to support 72 grants and contracts during fiscal year 1976: 30 new grant awards, 32 continuation grant awards, and 10 contracts. As an integral part of the Administration on Aging's comprehensive planning process, these awards are intended to study existing patterns and conditions of growing old, develop new approaches and strategies for improving a comprehensive system for service delivery for the elderly, and evaluating these conditions and approaches.

Under title IV–B (research), the Commissioner may make grants to any public or nonprofit agency, organization, or institution, and contracts with any agency, organization, institution, or individual. Research proposals directly relating to Older Americans Act programs and unsolicited proposals may be funded. However, in fiscal year 1976, the Office of Human Development (the HEW level between AoA and the Office of the Secretary) issued a written guidance stating that only "direct research" grants would be issued and it disallowed the agencies under its authority from supporting unsolicited research proposals. Although the Administration on Aging received over 200 unsolicited proposals from researchers throughout the country, very few were funded by title IV because of the Office of Human Development's policy regarding research awards. This practice of funding only solicited proposals related to actual programmatical issues has slowed down innovative and diversified research in the field of aging.

The grants and contracts funded during fiscal year 1976 are listed as follows:

TITLE IV–B RESEARCH GRANTS—NEW AWARDS

Project title	*Grantee*
1. Attitudes Toward Older Persons on the Part of Service Delivery Professionals.	Portland State University, Portland, Oreg.
2. Development and Adoption of Policies for the Elderly: The Legislative Process.	Northern Illinois University, DeKaib, Ill.
3. Consumerism and the Aging: The Elderly as Victims of Fraud.	Battelle Human Affairs Research Center, Seattle; University of Pittsburgh.
4. Cohort Experience and the Aging Population.	University of Southern California; Western Behavioral Sciences Institute, San Diego.
5. A Study of Opportunities for Socialization to Old Age.	Wayne State University, Detroit, Mich.; Duke University, Durham, N.C.
6. Successful Work Options of Aging Women.	University of Southern California, Los Angeles.
7. Informal Social Networks and Assistance Among the Aging.	Catholic University, Washington, D.C.

8. Development of an AoA Strategy for Policy Research on Aging: Adequate Income and the Elderly.	Urban Institute, Washington, D.C.
9. Development of an AoA Strategy for Policy Research on Aging: Housing and the Elderly.	University of Nebraska, Omaha, Nebr.
10. Development of an AoA Strategy for Policy Research on Aging: Employment, Retirement, and the Elderly.	University of Wisconsin, Madison, Wis.
11. Development of an AoA Strategy for Policy Research on Aging: Community Services and the Elderly.	Urban Institute, Washington, D.C.
12. Strengthening Decision Making for Alternative Approaches to Conducting In-Service Training.	Albert Einstein Medical Center, Philadelphia, Pa.
13. A Cross National Comparison of the Institutional Elderly; Including Costs, Quality and Outcome of Their Long-term Care.	Research Foundation for Mental Hygiene, Albany, N.Y.
14. Private Pension Plans and the Older Worker.	University of Maryland, College, Park, Md.
15. An Analysis of the Implications of Title XX Service Plans for the Nationwide Development of Local Comprehensive Service Delivery Systems for the Aged.	Scientific Analysis Corp., San Francisco, Calif.
16. The Elderly and Their Housing	Philadelphia Geriatric Center, Philadelphia, Pa.
17. Funding Practices, Policies and Performance of State and Area Agencies on Aging.	University of California, San Francisco, Calif.
18. Technology in the Service of the Aged Through the Retirement Cooperative Concepts.	Mitre Corp. McLean, Va.
19. Research Relating to Service Delivery Models for Pacific Asian Elderly.	Special Service for Groups, Los Angeles, Calif.
20. Implications of Prospective Population Change for Older American Workers.	University of Virginia, Charlottesville, Va.
21. Simulating Demand and Costs for Statewide Services to the Aging.	Penn State University, University Park, Pa.
22. Changing Household Patterns Among the Elderly.	Duke University, Durham, N.C.
23. Testing a Community Intervention Model.	Portland State University, Portland, Oreg.
24. Aging Competency	University of Maryland, College Park, Md.
25. Analysis of Coordination and Organization Change.	Portland State University, Portland, Oreg.
26. Impact of Unemployment Climate on Older Workers in Two Labor Markets with Contrasting Unemployment Rates.	American Institutes for Research, Washington, D.C.
27. Meaning and Correlates of Life Satisfaction in Older (and Middle Age) Blacks: A Secondary Analysis.	University of Michigan, Ann Arbor, Mich.
28. An analysis of Employment Services to Older Job Seekers.	Human Resources Research Organization, Alexandria, Va.
29. The Utilization of the Elderly in Child Welfare Services.	Division of Youth and Family Services, Dept. of Institutions and Agencies, Trenton, N.J.
30. Approaches to Determining the Cost of a Home Care Alternative to Nursing Home Care: The Diversion of Strategy.	Brandeis University, Waltham, Mass.

31. The Impact of National Health Insurance on Health Care for the Elderly.	University of Chicago, Chicago, Ill.
32. The Impact of Inter-Institutional Relocation on Geriatric Patients.	University of Utah, Salt Lake City, Utah.

TITLE IV–B RESEARCH GRANTS—CONTINUATION AWARDS FOR FISCAL YEAR 1976

Project title	*Grantee*
1. Identifying Opportunities for Improving the Quality of Life of Elderly.	American Institute for Research, Palo Alto, Calif.
2. Non-Chronological Definitions on Aging.	University of Southern California, Los Angeles.
3. Individual and Community Competence: A Study of the Successfulness of Coping Mechanisms of the Aged.	University of Maryland, College Park, Md.
4. Decision Making and the Elderly-----	University of Chicago, Chicago, Ill.
5. Local-Socio-Environmental Contexts and Personal Moorings Relating to Decision Making and the Elderly.	University of Missouri, Columbia, Mo.
6. Impact of Needs, Knowledge, Ability and Living Arrangements on Decision-Making.	Catholic University, Washington, D.C.
7. Organization of Cognitive Abilities and Old Age.	University of Florida, Gainesville, Fla.
8. Crises and Adaptation in the Middle and Late Years.	University of Chicago, Chicago, Ill.
9. Decision-Making Among Older Americans: An Analysis of Ecological, Psychological, and Biological Determinants.	Catholic University, Washington, D.C.
10. Foundations for Research in Social Problems of Aging.	University of Southern California, Los Angeles.
11. Development and Utilization of Relevant Cross-National Research in Aging.	Gerontological Society, Washington, D.C.
12. Integration of Information on Aging: Handbook Project.	University of Southern California, Los Angeles.
13. Diagnosis of Mental Disorders in the U.S. and U.K.	New York State Department of Mental Hygiene, New York, N.Y.
14. Better Services for Aging Through Research Utilization.	Governor's Committee on Aging, Austin, Tex.
15. Predicting Accuracy of Perceiving the Aging Person.	State University of Genesse, Albany, N.Y.
16. National Survey of the Aged---------	University of Illinois at Chicago Circle, Chicago.
17. Factors Influencing the Abandoning of Private Homes by the Elderly.	Regents of the University of Michigan, Ann Arbor, Mich.
18. Life Styles of the Aging and Consumer Behavior.	Regents of the University of California.
19. Client Oriented Community Assessments of Long-Term Care Facilities.	The Urban Institute, Washington, D.C.
20. A Comparison of In-Home and Nursing Home Care for Older Persons in Minnesota.	Governor's Citizen Council on Aging, St. Paul, Minn.
21. Planned Crisis Disaster-Nursing Home Closings.	Department of Community Medicine, Philadelphia, Pa.
22. Avocational Counseling for the Elderly.	Curative Workshop of Milwaukee, Milwaukee, Wis.
23. Planning for the Health Care Needs of the Elderly.	University of Massachusetts, Boston, Mass.
24. Need, Cost, and Effect of Home Services for the Aged.	Philadelphia Geriatric Center, Philadelphia, Pa.

25. A Study of Funding Regulations, Program Agreements and Monitoring Procedures Affecting the Implementation of Title III of the Older Americans Act.	Andrus Gerontology Center, USC, Los Angeles, Calif.
26. Analysis of Transportation Demonstrations for the Elderly.	Institute of Public Administration, Washington, D.C.
27. Committee on Research and Development Goals in Social Gerontology.	Gerontological Society, Washington, D.C.
28. Rehabilitation of Adults and Geriatric Blind.	New York Infirmary, New York City, N.Y.
29. Day Care Center for the Elderly----	Center for Community Research of the Associated YM-YWHA's of Greater New York-Montefiore Hospital and Medical Center.
30. Design Evaluation—Social Use of Elderly Housing.	Massachusetts Institute of Technology, Boston, Mass.

TITLE IV–B CONTRACTS FOR FISCAL YEAR 1976

Project title	*Contractor*
1. Sampling of the Elderly Population.	Westat, Inc., Rockville, Md.
2. Aggregation of the Elderly Population.	Roy Little John Associates, Washington, D.C.
3. Data Collection Problems and the Elderly.	JWK International, Annandale, Va.
4. Factors Related to Functional Dependency Among Older Persons.	Morgan Management System, Columbia, Md.
5. Instrument Bank: Assessment of Available Research and Measurement Scales for the Study of Aging and the Elderly.	Curators of the University of Missouri, Institute for Community Studies, Kansas City.
6. State of the Art: Attitudes Toward the Elderly in Professional Education Schools.	Joseph A. Davis, Consultant, Inc., New York.
7. Technical Assistance to the National Network on Aging: Handbook on Priority Services for Older Persons.	Community Research Applications, New York.
8. Prediction of Needs Through Analysis of Pre-Elderly Cohorts.	Roy Littlejohn Associates, Washington, D.C.
9. A Comprehensive Inventory and Analysis of Federally Supported Research in Aging 1966–1975.	Documentation Associates Information Services, Inc., Los Angeles.
10. The Racial and Ethnic Elderly Characterization Study (Interagency Agency Agreement).	U.S. Bureau of the Census, Washington, D.C.

C. Multidisciplinary Centers of Gerontology

For the first time since authorized in 1973, multidisciplinary centers of gerontology were funded in 1976. In the Labor-HEW appropriations for fiscal year 1976 the Congress included $1 million for such centers and an additional $1 million for the transitional quarter. For fiscal year 1977, the Congress increased title IV–C funds to $3.8 million for multidisciplinary centers of gerontology.

A "multidisciplinary center of gerontology" can be any nonprofit agency, organization, or institution which adheres to the requirements and duties as mandated by title IV of the Older Americans Act. Most multidisciplinary centers which have been funded by AoA are within post-secondary education institutions. Such centers must recruit and train personnel; conduct basic and applied research; provide consultation; serve as a repository of information; stimulate the incorpora-

tion of information on the aging; help to develop training programs on aging; create opportunities for innovative, multidisciplinary efforts in teaching, research, and demonstration projects; provide for proper administrative and accounting control; and be accountable for reports upon request from the Commissioner. The multidisciplinary center is just that—varied in disciplines and extensive in scope. Although colleges or universities might already have had a title IV career training grant, they may still be eligible for a title IV multidisciplinary center grant. As one component of its wide focus, the center has provided broader responsibility and direction than career training programs.

Twenty colleges and universities were supported by title IV–C multidisciplinary center grants in fiscal year 1976. Seven of the grants were awarded to institutions of higher education as operational grants to assist them in continuing or expanding gerontological programs that already existed. Thirteen other colleges and universities received developmental grants to assist them in taking the necessary steps to develop a multidisciplinary center on their campuses. Because of the limited amount of funds for such centers, $1 million for fiscal year 1976 and $1 million for the transitional quarter, only small amounts of support could be made for such centers, especially in developmental grants. It is projected that the $3.8 million allotted for fiscal year 1977 will assist in further supporting the existing programs and allowing for additional grants to be made for new multidisciplinary centers.

Those institutions receiving grants under title IV for multidisciplinary centers are:

Operational grants:
- Boston University.
- Duke University.
- Syracuse University.
- Miami University of Ohio.
- North Texas State University.
- University of Southern California.
- Pennsylvania State University.

Developmental grants:
- Florida State University.
- University of Iowa.
- University of Illinois at Chicago Circle.
- Sanders-Brown Center, University of Kentucky.
- University of Miami (Florida).
- University of Pennsylvania.
- Davis Institute for the Care and Study of the Aging, Denver.
- University of Alabama.
- University of Alabama in Birmingham.
- University of Hawaii.
- City University of New York.
- University of Connecticut.
- North Country Community College, Saranac Lake.

FINDINGS AND RECOMMENDATIONS

Statisticians project that by 2000 the elderly population will exceed 30 million. Yet, the process of aging is still subjected to many areas of the "unknown." Substantial steps have been taken in the last few years—the development of the National Institute on Aging, the creation of the Center for Studies of Mental Health of the Aging, and the increase of support for research and demonstration under the Older Americans Act—which are helping to fill many of the gaps of the unresearched areas.

However, the gaps are still numerous. The committee recommends:

—That the National Institute on Aging be given more adequate funding and equal standing with the other institutes under the National Institutes of Health (NIH);

—That the Center for Studies of Mental Health of the Aging be supported as a line item in the National Institute of Mental Health (NIMH) budget in order to give it the stability and support it needs to become an effective aging research center within the NIMH;

—That funds for research, training, and demonstration under the Older Americans Act (title IV) be increased to at least $35 million to meet the demand; and

—That careful attention and necessary action be given to the aging research plan for the Department of Health, Education, and Welfare which was prepared by the National Institute on Aging and the National Advisory Council on Aging.

CHAPTER IX

THE NATION'S RURAL ELDERLY

What is rural America? Ask Federal agencies, and the answer will vary. For example, according to ACTION, the Administration on Aging, and the Urban Mass Transportation Administration (DOT), "rural" is any community with 2,500 persons or less. Ask the Rural Highway Public Transportation Administration (DOT), you will learn that rural is a population of 5,000 or less. The Farmers Home Administration and the Legal Services Corp. define rural as communities with 20,000 or fewer residents. The Department of Housing and Human Development classifies rural as any area outside of the SMSA (standard metropolitan statistical area). The Social and Rehabilitation Service and several agencies under the U.S. Department of Agriculture define rural as areas with 50,000 residents or less.

Therefore, a population ranging from 1 to 50,000 would constitute a "rural" area, depending upon the Federal definition.

The Conference on Rural America defines "rural America" as areas with a population of 25,000 or less.

But to most persons, rural simply means the opposite of a city, urban life—a way of life without mass population, but with, perhaps, closer ties among the residents.

Life is often thought of as "better" in the country but in many instances this is not the case. The First Conference on Rural America held in 1975 in Washington D.C. and the second conference held in Des Moines, Iowa, in 1976 asserted that rural America's people are often neglected when Federal funds are distributed. The conferences cited such statistics as: 138 rural counties in America have no resident doctor; 146 bus companies have gone out of business in small cities and rural areas in the past 15 years (yet, the Department of Transportation places its emphasis on urban areas); and unemployment rates are higher in rural areas than metropolitan areas. Rural residents are also likely to be unemployed for a longer period than urban residents—yet, employment and manpower services are scarce in rural communities.

The Rural Development Act of 1972 was intended to give Federal aid to the rural areas in various categories.[1] However, its main focus, with the exception of the Farmers Home Administration's support of rural housing, has been on physical improvements: roads, sewer systems, and construction. Human services have been neglected in many areas. The lack of such services under the Rural Development Act and other Federal programs has had serious ramifications for the rural resident. The rural elderly have been dramatically affected by

[1] Public Law 92-419, signed into law on Aug. 30, 1972.

this neglect. For these and other reasons, the Senate Committee on Aging began hearings on "The Nation's Rural Elderly" in 1976.[2]

NEEDS OF THE RURAL ELDERLY

Studies completed by the Bureau of the Census since 1970 show that a surprisingly large number of persons migrate to the nonmetropolitan areas.[3] A substantial percentage of those migrating are retired persons. In 1970, the Bureau of the census indicated that approximately 7.8 million persons aged 60 and over lived in rural areas. Today, Rural America, Inc., estimates that over one-third of the Nation's elderly—approximately 11 million persons aged 60 and over—live in rural communities.

These rural elderly residents have been even more exposed to problems than have their counterparts in the cities: inadequate housing, inadequate or no transportation systems, severe lack of health services, little chance of employment, and isolation.

A. Transportation and the Rural Elderly

Two major Federal transportation programs provide funding for rural elderly and handicapped persons.

Section 16(b)(2) of the Urban Mass Transportation Act (UMTA) provides capital assistance grants for private nonprofit groups. These funds have been specifically used for specialized and demand-responsive systems, utilizing vans and small buses to meet the needs of the elderly and handicapped. However, the UMTA nonurbanized funds may be used for only capital purchases, and the recipients must find other sources to meet their operating expenses. This has often been a major obstacle for many rural communities in their efforts to support a transportation system for their elderly.

Transportation emerged as a major issue at the Committee on Aging's hearings on "The Nation's Rural Elderly" in August 1976. Witnesses in Nebraska, South Dakota, and Iowa told Senator Dick Clark that the lack of operational funds prevented them from receiving a bus, or if they did receive it, the bus was parked for several months to a year awaiting operational funds. Edward S. McMillin of Ottumwa, Iowa, told Senator Clark:

> When a system has updated its equipment, there is a need for operating assistance. In many grant applications the emphasis is on capital outlays, rather than operating expenses. That is one major point that needs attention, mainly because in rural Iowa the strain of operating a system cannot be met by a local support totally.[4]

The other source of Federal funds for rural transportation was the rural highway public transportation demonstration project (sec-

[2] "The Nation's Rural Elderly," part 1, Winterset, Iowa, Aug. 16, 1976, part 2, Ottumwa, Iowa, Aug. 16, 1976; part 3, Gretna, Nebr., Aug. 17, 1976; part 4, Ida Grove, Iowa, Aug. 17, 1976; part 5, Sioux Falls, S. Dak., Aug. 18 1976; part 6, Rockford, Iowa, Aug. 18, 1976. Hearings not printed as yet.

[3] The Bureau of Census, Department of Commerce, defines a nonmetropolitan area as an area with a population of 50,000 or less.

[4] Testimony before the U.S. Senate Committee on Aging, "The Nation's Rural Elderly," Ottumwa, Iowa, Aug. 16, 1976.

tion 147 of the Federal Aid Highway Act). Section 147 was a 2-year demonstration program to develop and improve public highway transportation systems in rural areas. Applications for section 147 funds were accepted on an individual basis from both public and nonprofit agencies.

Section 147 was only a 2-year demonstration project—$9.65 million for fiscal year 1975 and $15 million for fiscal year 1976. Critics claimed that this short-term funding arrangement is inadequate for programs to develop self-sufficient transit programs, particularly when termination of section 147 funds would result in the project's collapse. (For a more detailed account on transportation, see chapter VII.)

B. Housing and the Rural Elderly

Housing for the elderly in rural areas is supported by several Federal programs—Farmers Home Administration (section 515), Public Housing, section 202, housing for the elderly and handicapped and section 8 rental assistance.

The Farmers Home Administration (FmHA) of USDA makes direct loans under section 515 to nonprofit and limited-profit sponsors to finance rental or cooperative housing and related facilities for occupancy by low-income families and senior citizens 62 years of age or older. All States are eligible for FmHA (section 515) funds and awards are made on a sponsor basis in which families are charged no more than 25 percent of their income.

Public housing funds are provided by HUD to local housing authorities for the purpose of developing housing for low-income persons. HUD must distribute at least 15 percent of the public housing funds to "nonmetropolitan" (non-SMSA) areas and rental charges—based on one's income—cannot exceed 25 percent of that income. Subsidies to cover operating expenses for such housing projects are available from HUD on an annual basis.

Section 202 funds are long-term direct loans made by HUD to nonprofit sponsors of housing for the elderly. HUD was directed in 1974 to distribute at least 20 percent of the 202 funds to nonmetropolitan (non-SMSA) areas. In 1976, HUD directed about 19 percent of 202 funds to nonmetropolitan areas because, HUD claims there was lack of applications from sponsors in such areas.

Section 202 funds were discussed frequently during the Committee on Aging's hearings on rural needs of the elderly. Former Gov. Robert D. Blue of Iowa told Senator Clark:

> A lot of our housing programs are not geared to that 202 program. It is an excellent program but it does not extend itself to cover multifacilities. People are individuals; some of them want their own room, some of them want an efficiency apartment, some of them want two or three rooms, other people want the nursing services connected.[5]

Several other witnesses said many elderly cannot afford to live in 202 housing projects and "move down the street and rent substandard housing apartments in the neighborhood of $55 a month instead of

[5] Testimony before the U.S. Senate Committee on Aging, "The Nation's Rural Elderly," Rockford, Iowa, Aug. 18, 1976.

$98 a month." The need for subsidized housing was frequently voiced throughout the Midwestern States.

Section 8 enables HUD to provide housing subsidies to families with incomes not exceeding 80 percent of median income of their localities. Section 8 subsidies can be provided for use in newly built, extensively rehabilitated, or existing housing. Under section 8, low-income tenants pay no more than 15 percent of their income, while other eligible applicants pay no more than 25 percent. HUD section 8 funds are then used to make up the difference between what the tenant can pay and the "fair market rent."

The former administration emphasized section 8 as a means to use existing housing. However, section 8 has encountered difficulty in rural areas because suitable, vacant units are not available in great quantity.

In a related development, the U.S. District Court of the District of Columbia ordered Secretary of Agriculture Robert Bergland to reconsider whether HUD's section 8 rental housing program will adequately meet the goals of the rural rent supplement program as expressed by Congress. Secretary Bergland was to report to the court by late February of 1977 regarding whether rural persons can best be served by a separate FmHA rent supplement program or by existing HUD section 8.

Senators Eagleton and Bayh urged Secretary Bergland to utilize the authority granted to him as USDA Secretary under the Housing Act of 1974 to establish a separate FmHA program. In a letter dated February 9, 1977, Senators Eagleton and Bayh were joined by 26 other Senators stressing the urgency for implementing this program, which has been authorized since 1974.

Under their proposal, section 8 would be retained and would continue to provide direct loans to metropolitan areas.

Even though HUD and FmHA have several programs which support projects in rural areas, the need for more adequate housing for elderly persons in rural America is clearly evident. Mayor Theodore E. Murphy of Ida Grove, Iowa, expressed the view of many small town leaders:

> We have moved away from any attempt to develop housing under the so-called HUD program. It just seemed like we could not get HUD interested in a small community that needed a lesser number of units.[6] (For a more detailed account of housing for the elderly, see chapter IV).

C. Health Services and the Rural Elderly

> In years past we had three doctors. We had a dentist, we had a registered nurse—we had two or three. We had two trains a day and we were pretty well served. Today we have no doctor, no dentist, no RN. We are 18 or 19 miles away from any of those services and that has changed very decidedly the life of the people that live in our rural community.[7]

[6] Testimony before the U.S. Senate Committee on Aging, "The Nation's Rural Elderly," Ida Grove, Iowa, Aug. 17, 1976.

[7] Testimony by Miss Helen Storms of Western, Nebr., before the U.S. Senate Committee on Aging, "The Nation's Rural Elderly," Gretna, Nebr., Aug. 17, 1976.

This description of a small community in Nebraska is typical of many rural communities throughout the country. To drive 20 to 100 miles for a doctor or the hospital is common. On a national average, there is 1 physician per 500 persons. In rural areas this ratio is 1 doctor for every 2,400 persons.[8] Because of this shortage the nurse practitioner, physician extender, medex, and home health aide act as the primary health care provider in many communities.

The absence of physician and health centers in many rural areas is intensified for the elderly person, especially those covered under medicare. Medicare's effectiveness in rural areas is severely weakened because:

—The rural elderly pay the same premium for medicare as the urban elderly—despite the lack of local health facilities and personnel in rural communities, causing them to receive less service for their premium;

—Its inability to provide "fee for service" reimbursements for paraprofessional personnel; i.e., nurse practitioners and physician extenders;

—Its failure to allow rural health centers to be designated as "providers of service" so that they may be reimbursed based on average expenditure levels; and

—Its tendency to discourage doctors from practicing in rural areas because of what is regarded as inadequate reimbursements: Medicare payments are lower for rural doctors because they are based on fees charged in rural areas.

During the 94th Congress, several bills were introduced to improve health care in rural areas, including:

—Health Manpower Act of 1976 (enacted on October 12, 1976, as Public Law 94-484) would extend and improve the National Health Service Corp. to give incentive to medical graduates to relocate in medically underserved areas;

—S. 3661, which would allow the Secretary of HEW when determining certain standards for hospitals with 50 beds or fewer, to (1) consider availability of personnel in establishing personnel requirements, (2) waive the Federal fire and safety codes if stringent State codes were met, and (3) relax the prohibition against merging hospitals and nursing home patients in the same facility;

—Numerous bills to provide medicare reimbursement for more of the health care costs of the elderly patient—including, hearing aids, eyeglasses, dentures, and prescription drugs; and

—Several bills to allow "fee for service" reimbursement for paraprofessional personnel; that is, nurse practitioners and extended physicians.

Physical and financial obstacles to certain kinds of care have made home health care services especially appropriate for the rural elderly. However, medicare again is restrictive in its reimbursement for such care and, therefore, the demand for such services exceeds the availability.

When these services are available, they have been most effective in providing the elderly with the necessary care and allowing them to remain in their own homes instead of being placed in nursing homes.

[8] Statistics provided by Rural America, Inc.

A study conducted by home health agencies in Iowa shows 100 visits were made by public health nurses from June 1972 through April 1976 at a cost of $1,160, and 396 visits were made by home health aides at a cost of $2,962—for a total of $4,122. Nursing home costs in the same communities from June 1972 through April 1976 (1,418 days at $17.59 per day) would have amounted to $24,814. (For a more detailed description of home health care and other health services see chapter II.)

FINDINGS AND RECOMMENDATIONS

In view of the inequities in Federal services throughout rural America, confirmed by the committee's firsthand observation during field hearings on "The Nation's Rural Elderly," the committee recomends:

- **—Liberalization of medicare, with suitable controls, to allow reimbursement of paramedical personnel operating out of rural clinic settings with periodic review by physicians;**
- **—The adoption of more flexible standards under the medicare and medicaid programs for rural hospitals with 50 beds or fewer;**
- **—Continuation of the National Health Service Corp. program to increase the availability of physicians and dentists in rural medically underserved areas;**
- **—Increased outreach efforts by State and local agencies to inform elderly homeowners of potential assistance under FmHA's section 504 home repair grant and loan program;**
- **—The implementation of an effective rural rent supplement program;**
- **—HUD should encourage technical assistance programs to help nonmetropolitan sponsors in the preparation of satisfactory applications for section 202 in order that the 20-percent goal for nonmetropolitan awards is met;**
- **—The continuation of support for a program like section 147 of the Federal Aid Highway Act to fund transit systems for rural areas;**
- **—Allowing UMTA funds for areas with less than 50,000 population to use funds for operational as well as capital costs; and**
- **—All Federal programs should, where feasible, mandate that a particular proportion of their support be directed to rural communities.**

The Committee on Aging will continue its scrutiny of rural issues effecting older Americans.

CHAPTER X

A CALL FOR ACTION ON CRIME

A shocking upsurge in violent crimes committed against elderly residents of New York City brought to national attention in 1976 the deteriorating situation which has made older Americans prisoners within their own homes. Mayor Abraham Beame increased special efforts aimed at reducing crime, and State legislators called for stiffer penalties.

I. THE STATISTICAL BASE

In May, the Law Enforcement Assistance Administration (LEAA) released the first national crime figures based on statistical sampling techniques rather than police department records.[1] Interviews with 65,000 households revealed that the increase in violent crimes against the elderly was much more rapid than for other age groups,[2] even though the victimization of older Americans was at a lower rate than for the general population.

This LEAA report casts doubt on the validity of police-report-based crime statistics, concluding that only 42.5 percent of violent crimes are ever reported to law enforcement authorities. Nonetheless, figures compiled from police records confirm that crime continues to grow, especially in nonurban locales.[3] And a compilation of New York City's police reports for the first 9 months of 1976 indicated that crime in America's largest city was at an all-time record high.[4] Nationwide, only one-fifth of the serious crimes reported to police in 1975 ever resulted in an arrest.

Statistical shortcomings make it difficult to gage exactly what effect criminal activity is having on older Americans. This is caused in part by overlapping, contradictory, and incomplete data. At least 12 Federal bureaus and offices collect crime statistics in widely varied forms. The LEAA survey is one of the few information source correlating crime with the victim's age. Deputy Attorney General Harold Tyler has proposed that statistical gathering be centralized within a semiautonomous Bureau of Criminal Justice Statistics, which would report directly to the Attorney General.[5]

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[1] "Criminal Victimization in the United States: A Comparison of 1973 and 1974 Findings," National Crime Panel Survey Report No. SD–NCP–N–3, May 1976.

[2] For example, between 1973 and 1974, crimes of violence went up 1.5 percent overall but 6.5 percent for persons 65 and older. Personal larceny with contact went up 1.6 percent overall but 6.5 percent for persons aged 65 and older; assault was up 0.1 percent overall but 46 percent for the 65-plus group; and rape increased 4.3 percent generally but 66.7 percent for the elderly.

[3] The FBI's uniform crime report showed an 18 percent rise in serious crime in 1974, the largest annual increase in the report's 45-history. The report also showed a 10 percent rise in 1975, and a 3 percent increase for the first half of 1976. Additionally, the 1975 rate of increase was 7 percent in cities (population exceeding 250,000), 8 percent in rural areas, and 10 percent in suburbs.

[4] New York Post, Nov. 10, 1976, pp. 4 and 27.

[5] Wall Street Journal, Sept. 2, 1976.

II. LEGISLATIVE INITIATIVES

A. The Crime Control Act of 1976

The Crime Control Act [6] addresses the problem of elderly victimization through a combination of comprehensive planning and funding. LEAA's life was extended by the act through the end of fiscal year 1979. It authorizes $880 million for fiscal 1977 and $800 million for both fiscal 1978 and 1979. The act requires States receiving Federal funds to establish a planning agency to develop a comprehensive State plan for the improvement of law enforcement and criminal justice, coordination of State activities, and establishment of priorities.

The plan must meet certain criteria to be approved for funding. One requirement is that it must provide for the development of programs and projects to prevent crimes against the elderly, unless the State planning agency can make an affirmative finding that the requirement is inappropriate. This qualifying language is intended to exempt a State which can show that it has no substantial problem of crimes against the elderly. Senator Harrison Williams outlined his hopes for this provision:

> Hopefully, LEAA funds will be used for increased building security, escourt services, improved lighting, and new strategies aimed at turning the tide of personal assaults. Education can be a useful weapon too in alerting the elderly to the traps laid by con men and the purveyors of various frauds.[7]

The State plan requirement is not the sole feature of the Crime Control Act which will benefit older Americans. The act also establishes an office of community anticrime programs within LEAA to provide technical assistance to community and citizens groups to enable them to apply for grants and coordinate their activities with other Federal agencies and programs. The office will disseminate information about successful services to citizen and community groups. Advocacy organizations representing older citizens may use the office's resources to assure that the crime problems of the aged are adequately addressed within their communities. The State planning agency is required to assure that all citizen and community organizations participate at all levels of the planning process.

Mr. Ben Holman, Director of the Justice Department's Community Relations Service, has encouraged the residents of inner-city black neighborhoods to utilize these new funds in a grass-roots campaign against crime.[8]

The signing of a statement of understanding between AoA and LEAA represents another important development designed to reduce victimization of the elderly. This agreement may sensitize police agencies to the problem.[9]

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[6] Public Law 94-503, enacted Oct. 15, 1976.
[7] Congressional Record, vol. 122, No. 112, July 26, 1976, p. S 12451.
[8] New York Times, Oct. 8, 1976, p. 4; Oct. 12, 1976.
[9] AoA Information Memorandum 76-66, May 10, 1976.

B. Future Legislative Directions

State and local governments have primary responsibility under our Federal system for responding to the problems of victimization of older Americans. Congressional action, such as the 1976 Crime Control Act, can assist the States, though.

One example now being tested in 17 States is compensating the victims of crime for personal injuries suffered, or their surviving dependents in the case of homicides. The Senate has passed bills in prior years to underwrite the costs of such State programs, but the House has never approved this legislation because of disagreements concerning the amount of Federal regulation to accompany such financial backing.[10] Such legislation, which could alleviate at least a portion of the distress caused by victimization, may well be implemented in the future. On the other hand, there are serious questions, including:

—Whether the Government should begin to underwrite such losses, and

—Whether the money may be more prudently used by attacking the root causes of elderly victimization, such as decaying cities, inadequate income, social isolation, nonresponsive social and judicial institutions, and high teenage joblessness.

III. NEW YORK CITY—AN APPALLING SIEGE

The present situation in New York City, as described in news accounts, is a disturbing illustration of what the national upswing in crimes against the elderly means in personal terms:

—"The brutality is worse, the beatings are awfully bad," remarked Sgt. James Bolte of the Bronx senior citizens robbery unit. His recent cases have included many so-called "push-in" or "crib job" robberies, wherein the victims are assaulted as they are entering their homes. In many of those cases the elderly have been locked into closets after being beaten and robbed; two such victims died of heart attacks—in one of those instances a woman remained trapped with the body of her husband for 3 days.[11]

—A 1974 survey conducted by New York City's Department for the Aging estimated that 41 percent of the city's elderly had been victims of muggings, robberies, or burglaries.[12] In an extreme example, practically all elderly members of the Mount Eden Center in the Bronx have been mugged at least once. Mrs. Clara Engelman, 64, sleeps fully clothed in the foyer of her apartment so she can escape quickly if burglars enter, as they have done three times previously.[13]

—On October 2, 1976, Hans and Emma Kabel were robbed and assaulted in their Bronx apartment for the second time in a month. Finding nothing, the robbers tortured the Kabels with a cooking fork. Four days later Hans and Emma committed suicide

[10] National Senior Citizens Law Center Newsletter, Oct. 8, 1976, pp. 2–3; "Crime Victim Compensation," hearings before the Subcommittee on Criminal Justice of the Committee on the Judiciary, House of Representatives, Ser. No. 39, 1976.
[11] New York Times Oct. 24, 1976.
[12] New York Daily News, Oct. 25, 1976, p. 21.
[13] New York Times, Nov. 12, 1976, pp. B1 and B6.

together, leaving a note that read, "We don't want to live in fear anymore." [14]

—A 64-year-old Brooklyn polio victim was assaulted in her wheelchair by a knife-wielding assailant. She was robbed of $50, raped, and beaten until she lost the sight in her one good eye.[15] Elsewhere in that borough, a 103-year-old resident of the Bedford-Stuyvesant area was knocked from her walker to the ground and relieved of her $2 bag of groceries by two boys aged 12 and 14.[16]

A. The Response

Incidents such as those just described have led to new initiatives in New York City. Among the major reactions and proposals:

Police Assignments and Methodologies.—In a letter to Committee on Aging Chairman Frank Church, New York City Police Commissioner Michael J. Codd recounted the history and operational effectiveness of the department's senior citizens robbery unit: [17]

> In October 1974, the senior citizens robbery unit was established in the county of the Bronx, utilizing one (1) sergeant, six (6) detectives and two (2) police officers. The purpose was to address residential and dwelling robberies being committed against elderly citizens in specific areas of the Bronx. The mission of the unit was to bring the police to the elderly, concentrate on groups that robbed senior citizens and to coordinate intelligence information on a countywide level.

By implementing a number of innovative methods of identifying perpetrators, educating older citizens, and assisting victims in their court appearances, Commissioner Codd reports that the unit made several significant advances:

> Their conviction rate was over 90 percent. In addition, the unit has assisted in the investigation and solution of 17 robbery homicides. . . . Many of the perpetrators arrested have been members of groups that have been preying exclusively on the elderly. As a result of these arrests and the attendant notoriety, the criminal elements can no longer believe that their crimes against the elderly will go unreported to the police.
>
> . . . A close working liaison has been established between this department and the mayor's office of the aging. Further, a system is being developed whereby any and all social resources needed by an elderly crime victim can be obtained by one telephone call from the police to the social services coordinator.

The unit has also employed statistical analyses to pinpoint the extent of elderly victimization. The first study, based on 1975 complaints to the police, revealed that persons over 60 reported 26.8 per-

[14] Washington Star, Oct. 10, 1976, pp. A1 and A7.
[15] New York Post, Nov. 5, 1976.
[16] New York Times, Nov. 11, 1976.
[17] Senator Church's letter and the complete text of Commissioner Codd's reply are reprinted in part 2, appendix 6, of this report.

cent of the residential robberies in that year while constituting only 17.6 percent of the city's population.

At a news conference, Mayor Beame characterized attacks against the elderly as "the sickest and most repugnant kind of crimes." He then announced the expansion of the roberry unit concept to New York's other boroughs and the quadrupling of its staff to 84 officers.[18] Later reports indicate that the new units would not copy the methods developed in the Bronx but would tailor their strategies to individual borough conditions. In addition, precinct detective units would continue performing investigative duties.[19]

The police department has also asked its 5,000-member auxiliary police force to increase daytime patrols, particularly along routes frequented by elderly citizens. This group of unarmed and unpaid voluntary officers had formerly operated mainly between 7 p.m. and midnight. Leaders of the auxiliary force requested its members be permitted to make arrest and carry firearms. But the president of the Patrolmen's Benevolent Association, which has seen 3,000 regular officers laid off during New York's fiscal crisis, charged that the auxiliaries were "costumed police officers designed to lull the community into a false sense of security." [20]

Judicial and Penal Reform.—On December 5, 1976, more than 200 elderly Bronx residents attended a rally at which various speakers proposed revisions in the State's criminal code, including proposals for treating all offenders over age 14 as adults in court, although they might not be sent to adult correctional facilities; restoring capital punishment; making juvenile records available to judges for sentencing rather than sealing them when the person reaches age 16; increasing penalties for all offenses against the elderly, with plea-bargaining forbidden; and sentencing youthful offenders to a term of community service. But New York's Governor Carey has gone on record in opposition to treating persons under 16 as adults. And civil libertarians have objected to the release of family court records to adult division judges because youthful offenders do not receive adult procedural safeguards.[21]

Members of the Bronx senior citizens unit have complained that they are hampered by the prohibition against taking the photograph or fingerprints of persons under 16. They also feel that most arrested youths are immediately "recycled" onto the street. In New York, youthful offenders cannot presently be sentenced to terms exceeding 3 years; in practice, only a handful are confined more than 15 months and most are released in less than a year.[22]

The publicity surrounding the upsurge in violence against the elderly seems to have produced a wave of public indignation,[23] and more severe sentencing. For example, in November, a 17-year-old girl

[18] New York Daily News, Oct. 30, 1976, pp. 3 and 15.
[19] New York Sunday News, Nov. 14, 1976, p. M10.
[20] New York Times, Nov. 14, 1976; New York Sunday News, Nov. 14, 1976, pp. 3 and 110.
[21] Reform proposals were culled from the following sources: New York Daily News, June 8, 1976, p. 26; Dec. 9, 1976, p. 5; Dec. 10, 1976, p. 19; and New York Times, Dec. 6, 1976, p. 61.
[22] New York Times, Oct. 30, 1976, p. 38; Nov. 13, 1976, p. 11.
[23] A New York Daily News, Nov. 29, 1976, opinion poll, based on the random telephone sampling of 532 adults, found that 82 percent felt that juveniles charged with murder, rape, or assault should be treated as adults; 82 percent felt that the juvenile records of major offenders should be available to the courts and police; and 83 percent felt that the courts were too lenient.

who helped rob an 84-year-old woman at knifepoint was given a 7-year term.[24] Some of those who work within New York's family court system have speculated that the stiffer penalties are resulting in a shift in crime targets. Manhattan Judge Manuel Guerrio says that the street grapevine has passed the word that "the social worker syndrome has diminished." He characterized that philosophy as one which emphasizes treatment rather than punishment.[25]

New statistics may support that belief. Juvenile arrests for crimes against property appeared headed for an alltime high in New York City for 1976, but arrests of juveniles for violent crimes have declined. On the other hand, those statistics may be the result of the cutbacks in New York's police ranks or the victim's fear of reprisal. Members of the Bronx senior citizens robbery unit estimate that 30 to 40 elderly victims remain silent for each 1 reporting a crime to the authorities,[26] because of fear or cynicism.

Those concerned with the juvenile justice system in New York will follow the performance of a new plan which takes effect in February 1977. The Juvenile Justice Reform Act permits family court judges to mandate 1-year terms in secure training schools for youthful murderers, arsonists, and kidnappers. Following that year, there can be an additional one in a residential setting, which may be followed in turn by 3 years probation.[27] If the act is not successful in cutting serious juvenile crime, then the debate over still sterner approaches will undoubtedly intensify.[28]

Other Measures.—In September, a new organization, the senior citizens crime prevention program, began functioning in Manhattan and the Bronx. It offers direct, over-the-phone counseling, conducts neighborhood crime-prevention training programs, and aids elderly victims. It is funded by a $129,000 LEAA grant administered jointly by the State Department of Criminal Justice and the city department of aging.[29] The department of aging has also just been awarded a $20

[24] New York Times, Nov. 10, 1976, p. 21.
[25] New York Times, Nov. 29, 1976, p. 31.
[26] New York Times, Nov. 13, 1976, p. 11.
[27] References cited in footnote 20.
[28] While criminal activity cannot be excused, the long-term solution to the new juvenile crime wave may well require more than just increased police protection and sterner courts. On Oct. 27, 1976, New York State Senator Ralph Marino, chairman of the legislature's select committee on crime, released the family court records of 19-year-old Ronald Timmons. Mr. Timmons, who had been released on $500 bail after allegedly beating an 82-year-old woman in the Bronx, had a long history of juvenile offenses, particularly crimes against the elderly. That record was not available to the judge who set bail. Mr. Timmons, after jumping bail, was apprehended in Baltimore, Md., on November 17 and remanded to Bellevue Hospital for psychiatric examination.

An in-depth New York Times profile of Ronald and his twin brother Raymond stated that they were regarded as the "godfathers" of "crib" crimes against the elderly in their Bronx neighborhood. The article recounts the migration of their parents from South Carolina to New York in the mid-1950's. Of the twins, it also observes that they:

". . . slowly but surely developed patterns of antisocial behavior as children. But if they became predators, they were also victims of serious failures, first from within a weak, fragmented and unreliable family structure; then from a system of justice that neither perceived the scope of their problems nor offered the brothers meaningful rehabilitation.

As a consequence, their potential victims received almost no protection from their antisocial activities. . . . Almost all of the serious allegations against them as children went without adjudication in a hopelessly overcrowded family court and their records there remain a hopelessly disorganized, incomplete jumble. . . ."

Ronald and Raymond were first arrested, for purse snatching and assault, at age 12. Their first adult conviction occurred in February 1974, 3 months after they were released from training school. Raymond Timmons is presently incarcerated in New York's Coxsackie correctional facility after pleading guilty to robbery in the second degree. He is due for release in July 1977. Ronald Timmons was paroled from prison in February 1976 and allegedly beat his 82-year-old victim in October—The New York Times, Dec. 14, 1976, pp. 1 and 42.
[29] New York Daily News, Nov. 9, 1976, p. 7.

million Federal grant for an outreach program that will help to staff the prevention program and will provide services designed to counter the isolation and meet other needs of New York's elderly.[30]

B. Community Concern and Community Action

Community concern has also been demonstrated in several ways. Major examples include:

THE NATIONAL BICENTENNIAL CONFERENCE ON JUSTICE AND OLDER AMERICANS

The National Bicentennial Conference was held in Portland, Oreg., September 26–29, and was sponsored by the Multnomah County Division of Public Safety. The conference brought together law enforcement, social service, and legislative personnel from the State and Federal levels. Its purpose was to promote the exchange of different ideas and approaches concerning the best means of satisfying the judicial needs of older Americans.

Multnomah County has been developing an older Americans crime prevention program with the assistance of LEAA funding since 1975. To date that program has been researching the characteristics and extent of elderly victimization. Gathering of data is now nearly complete. In 1977 the program will design a followup education and prevention strategy.[31]

ACTIVITIES OF NATIONAL SENIOR ORGANIZATIONS

Two major national senior advocacy groups have become involved in crime preventive efforts.

The National Retired Teacher's Association (NRTA) has helped develop an educational program which aims to help the elderly avoid victimization. This crime prevention program consists of four 2-hour sessions dealing with street crime, residential burglaries, criminal fraud, and police-community relations. In 1975, these presentations were made to more than 600 NRTA chapters and other community organizations. And, in April 1976, NRTA received a $224,000 LEAA grant for an 18-month project aimed at developing a training course for law enforcement personnel to sensitize them to the special needs of older victims. NRTA has already hosted more than 100 seminars for police officers across the Nation since 1973.[32]

The National Council of Senior Citizens (NCSC) has been selected as the coordinator of a nationwide program to prevent crime against the elderly through various strategies. Other participants will include

[30] New York Daily News, Sept. 25, 1976, p. 18.

[31] Persons wishing further information about the conference and its results should address inquiries to: Marlene A. Young Rafal, Multnomah County Crime Prevention Unit, 10523 Cherry Blossom Drive No. 101, Portland, Oreg. 97216. Some of the topics explored in general sessions and in workshops were: Criminal and social victimization; research, planning, and evaluation of prevention programs; legal services; secure housing design; consumer and drug problems; police sensitization and victim services; the impact of ethnicity on service delivery; legislative priorities; and the problems of older persons residing in nursing homes and single room occupancy hotels.

On December 31, 1976 Multnomah County published the Final Report on its Older Americans Crime Prevention Research Project. The Project's purposes were to gather data on the criminal victimization of older adults; the relationship of the older adult to the criminal justice system; and the cognitive understanding of the legal system by the older adult.

[32] NRTA News Bulletin, vol. XVII, No. 6, June 1976, p. 8.

the National Council on the Aged, American Association of Retired Persons, International Association of Chiefs of Police, and some member cities of the Urban Elderly Coalition. This LEAA-sponsored consortium has already received a $200,000 commitment from that agency, as well as $750,000 from the AoA and $100,000 from HUD. The Community Service Agency may also participate. Full operations are awaiting a determination whether there will be a matching grant requirement from the participants and what portion of program activities will be devoted to victim assistance.[33]

ADDITIONAL STUDIES AND ACTIVITIES

Architect Oscar Newman, known for coining the term "defensible space," issued a new report which suggests that mixing different age groups in public housing promotes elderly victimization. This joint LEAA–HUD study found that elderly residents of New York City mixed-aged housing were crime targets 350 percent more often than younger tenants. It recommended that, particularly in regard to high-rise construction, buildings should be set aside for exclusive residence by older persons.[34]

A 3-year study undertaken by the Kansas City Police Department, under a grant from the National Institute of Law Enforcement and Criminal Justice, has implied that prompter reporting of crimes could have a far more beneficial effect on the arrest rate of perpetrators of the most serious offenses than large expenditures on communications and transport equipment. In Kansas City, delays in reporting these crimes occurred 76 percent of the time. Victims of residential burglaries initially called someone other than the police in 94 percent of the cases. The same was true for 71 percent of street robbery victims. These delays often allow the perpetrator to escape, negating the effectiveness of radios, squad cars, and other such devices which can hasten the arrival of police on a crime scene.[35]

Two new developments in New York provide an otherwise encouraging note in the reports coming from that city. The "early alert" program aims to create a network of relatives, friends, volunteers, and neighborhood postmen who will maintain friendly surveillance over neighborhood elderly.[36] And about 400 students of Taft High School in the Bronx are attempting to overcome barriers of age and ethnicity by providing an escort service for the fearful older residents of their Morrisania neighborhood.[37]

A new resource for those interested in establishing a local crime prevention program is being published by the International Association of Chiefs of Police with the support of an AoA model projects grant. The "Directory of Crime Prevention Programs for Senior Citizens" contains information about the activities, benefits, and costs of over 40 such programs undertaken by communities throughout America.[38]

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[33] Conversation with David Marlin, director, and Harriette Fox, planner, Legal Research and Services for the Elderly, NCSC, Washington, D.C., Dec. 8, 1976.
[34] Washington Star, July 19, 1976, p. 2; July 23, 1976, p. D6.
[35] Washington Post, Nov. 14, 1976, p. B6.
[36] New York Post, Dec. 1, 1976, p. 34.
[37] New York News, Dec. 14, 1976; New York Post, Dec. 15, 1976, p. 35.
[38] For information contact: Technical Research Services Division, IACP, 11 Firstfield Road, Gaithersburg, Md. 20760.

CHAPTER XI

AREAS OF CONTINUING OR EMERGING CONCERN

Once again in 1976, Federal programs and policies on aging interacted with a wide range of emerging or existing problems or encouraging new developments, some of which are discussed in this chapter.

I. MINORITY CONCERNS

Census data gathered in 1976 [1] revealed that elderly persons in minority groups—who suffer deeper extremes of deprivation and hardship than aged whites—were severely hit by the 1974–75 recession.

Poverty among aged blacks, for example, increased by 10.3 percent, from 591,000 in 1974 to 652,000 in 1975. The number of aged Spanish persons who were poor jumped by 17.1 percent, from 117,000 to 137,000 during this same period. Poverty among aged whites also increased, but not as sharply as for members of elderly minority groups. The number of aged poor white persons rose by 7 percent, from 2.46 million to 2.634 million.

In fact, the likelihood of being poor among elderly blacks is almost three times (2.7 times) as great as for aged whites. Nearly three out of every eight older blacks (36.3 percent) were impoverished in 1975. And over half (51.6 percent) of all blacks 65 or older lived in poverty or near poverty.

POVERTY BY RACE AMONG PERSONS 65 OR OLDER

[In thousands]

	1975			1974		
	Total noninstitutionalized population	Poor	Percent poor	Total noninstitutionalized population	Poor	Percent poor
Whites	19,654	2,634	13.4	19,206	2,460	12.8
Blacks	1,795	652	36.3	1,721	591	34.2
Spanish	420	137	32.7	405	117	28.8

[1] The March 1976 Bureau of the Census survey is based on 1975 income for individuals.

ELDERLY PERSONS BY RACE WITH INCOMES BELOW 125 PERCENT OF THE POVERTY THRESHOLDS

[In thousands]

	Total noninstitutionalized population	Poor and near poor	Percent poor and near poor	Total noninstitutionalized population	Poor and near poor	Percent poor and near poor
Whites	19,654	4,516	23.0	19,206	4,283	22.3
Blacks	1,795	926	51.6	1,721	880	51.2
Spanish	420	181	43.2	(1)	(1)	(1)

[1] Not available.

Source: Bureau of the Census.

The 1976 Bureau of the Census survey also makes it clear that elderly minority members who live alone or with nonrelatives are probably among the most economically disadvantaged groups in our society today. Nearly three out of four (74.8 percent) elderly blacks living alone or with nonrelatives were classified as poor or near poor. For the Spanish aged who were similarly situated, nearly two out of three (66.2 percent) were either poor or marginally poor.

Elderly black women living alone or with nonrelatives live under extreme economic hardship. Almost four out of five—or 78.4 percent—live in poverty or near poverty.

POVERTY BY RACE AND FAMILY SIZE AMONG PERSONS 65 OR OLDER

[In thousands]

	1975					1974				
	Total noninstitutionalized population	Poor	Percent poor	Poor and near poor	Percent poor and near poor	Total noninstitutionalized population	Poor	Percent poor	Poor and near poor	Percent poor and near poor
All races—living in families	14,811	1,192	8.0	2,191	14.8	14,615	1,110	7.6	2,037	13.9
All races—living alone or with nonrelatives	6,851	2,125	31.0	3,304	48.2	6,512	1,975	30.3	3,191	49.0
Males—living alone or with nonrelatives	1,477	410	27.7	621	42.0	1,466	378	25.8	588	40.1
Females—living alone or with nonrelatives	5,374	1,716	31.9	2,683	49.9	5,046	1,597	31.7	2,604	51.6
Whites—living in families	13,454	898	6.7	1,693	12.6	13,321	836	6.3	1,567	11.8
Whites—living alone or with nonrelatives	6,200	1,736	28.0	2,823	45.5	5,885	1,624	27.6	2,716	46.2
White males—living alone or with nonrelatives	1,255	299	23.8	476	37.9	1,244	294	23.7	454	36.5
White females—living alone or with nonrelatives	4,945	1,437	29.1	2,347	47.5	4,641	1,330	28.7	2,262	48.7
Blacks—living in families	1,196	286	23.9	478	40.0	1,143	256	22.4	435	38.1
Blacks—living alone or with nonrelatives	599	366	61.1	448	74.8	578	335	58.0	445	77.0
Black males—living alone or with nonrelatives	199	103	51.7	134	67.6	197	75	38.4	118	59.8
Black females—living alone or with nonrelatives	400	263	65.7	313	78.4	381	260	68.2	327	85.8
Spanish—living in families	313	81	26.7	110	35.1	315	70	22.2	98	31.1
Spanish—living alone or with nonrelatives [1]	107	56	52.5	71	66.2	90	47	52.8	69	76.7

[1] Sample too small for reliable data on Spanish males and females living alone or with nonrelatives.

Source: Bureau of the Census.

Greater deprivation among aged minority groups takes it toll in many ways: substandard housing, hunger and malnutrition, a shorter life expectancy, a higher morbidity rate, and despair. It also accounts for a much higher representation of minority aged persons in the supplemental security income program, which is designed to build a Federal floor ($167.80 a month for qualifying individuals and $251.80 for eligible couples) under the incomes of the aged, blind, and disabled. Elderly blacks, for instance, constitute about 8 percent of the total 65-plus population. However, they account for 24.1 percent of aged SSI recipients who reported their race.

FEDERALLY ADMINISTERED SUPPLEMENTAL SECURITY INCOME PROGRAM BY RACE[1]

	Number	Percent white	Percent black	Percent other races
Total	4,300,000	63.5	26.0	[2] 2.5
Aged	2,200,000	64.9	24.1	7.6
Blind and disabled	2,100,000			
Blind	76,820	60.6	28.9	2.5
Disabled	2,007,047	61.9	28.0	2.4

[1] The aggregate figures were tabulated by the Social Security Administration for the month of August 1976. However the percentage figures were obtained for the month of June 1976.
[2] The percentages do not add up to 100 percent because not all persons reported their race.

Source: Social Security Administration.

Many older Americans did not become poor until they became old. But among minority groups, poverty in old age is frequently an extension of a life of deprivation during the earlier years. Lower earnings, discrimination, and more interrupted employment patterns contribute to lower social security benefits among minority members. Average monthly benefits for black retired workers ($168) are 80 percent of those received by retired white workers ($210).

A 1976 social security survey also reveals that black social security beneficiaries tend to be underrepresented among retired workers. Negroes account for 10.1 percent of all social security beneficiaries but only 7.7 percent of all retired workers. Two key reasons may account for this:

(1) Blacks have a shorter life expectancy than whites. Many elderly Negroes never live to age 62 (the earliest age a retired worker can receive actuarially reduced benefits) or 65 (the earliest age a retired worker can receive full benefits).

(2) Many older blacks worked in occupations (e.g., domestic employment and farm labor) not initially covered by social security. Consequently, they never obtained the required quarters of coverage to qualify for retirement benefits.

However, a greater proportion of blacks (14.7 percent) are disabled beneficiaries. In addition, Negroes constitute 20.4 percent of all survivor beneficiaries among children. This is attributable to two important factors:

Blacks have a higher birth rate than whites; and

The life expectancy among Negro workers is lower than for white covered employees.

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BENEFITS IN CURRENT-PAYMENT STATUS: NUMBER AND AVERAGE MONTHLY AMOUNT BY BENEFICIARY GROUP AND RACE, AT END OF 1975

Beneficiary group	Total	White	Black	Other
	Number (in thousands)			
Total	32,085	28,406	3,247	432
Men	10,920	9,827	942	151
Women	16,193	14,741	1,310	142
Children	4,972	3,838	995	139
Under age 18	3,835	2,899	820	116
Disabled, age 18 and over	362	320	37	5
Students, age 18 to 21	774	618	138	18
Retired workers and dependents	20,098	18,285	1,564	249
Retired workers	16,588	15,133	1,285	170
Wives and husbands	2,867	2,672	156	39
Children	643	480	123	40
Disabled workers and dependents	4,352	3,571	708	71
Disabled workers	2,489	2,090	367	31
Wives and husbands	453	381	63	8
Children	1,411	1,100	278	32
Survivors of deceased workers	7,411	6,334	969	108
Widows and widowers	3,889	3,606	255	28
Widowed mothers and fathers	582	452	116	14
Children	2,919	2,258	595	66
Parents	21	18	3	(1)
Special age-72 beneficiaries	223	215	7	2
	Average monthly amount			
Retired workers	$207	$210	$168	$190
Men	228	232	188	200
Women	182	185	146	159
Disabled workers	226	231	197	205
Men	244	250	215	216
Women	185	190	160	172
Aged nondisabled widows and widowers	194	197	153	163
Widowed mothers and fathers	147	157	114	115
Surviving children	139	149	107	108

[1] Less than 500.

Source: Social Security Administration.

A. Major Actions Affecting Elderly Blacks

The year 1976 produced some setbacks for aged and aging blacks, most notably in the area of income. But on other fronts—in housing, employment, training, and research—some impressive gains were recorded.

The National Center on the Black Aged, for example, received a $1.035 million loan from the Department of Housing and Urban Development under the section 202 program to construct housing units for the elderly in the District of Columbia. NCBA plans to begin construction in early 1977.

In addition, NCBA received a $100,000 title IV–A grant from the Administration on Aging to promote the training of minority professionals and volunteers in gerontology. The program involves eight minority schools,[2] four gerontology centers,[3] and eight State offices on aging.[4] One faculty member and an administrator of the minority in-

[2] The eight minority institutions are: Federal City College (Washington, D.C.), Fisk University (Nashville, Tenn.), Bishop College (Dallas, Tex.), Livingstone College (Salisbury, N.C.), Our Lady of the Lake College (San Antonio, Tex.), Southern University (New Orleans, La.), Albany State College (Albany, Ga.), and Adams State College (Alamosa, Colo.).

[3] The four gerontology centers are located at the University of Michigan, University of Southern California, Syracuse University, and North Texas State University.

[4] The eight State offices on aging include: New York, Washington, D.C., Georgia, North Carolina, Tennessee, Louisiana, Colorado, and Texas.

stitutions will visit one of the four gerontology centers to (1) observe the center's gerontology program as a possible model to improve and upgrade the minority institution's gerontology program, and (2) study the curricula at the gerontology centers for purposes of integrating a minority content in the curricula. The faculty member and administrator team will then spend a week in the spring of 1977 at State offices on aging to provide more effective coordination of short-term training programs between the minority institutions and the State agency. Afterwards, representatives from the minority institutions, State agency directors, and representatives from the gerontology centers will meet and present papers on curriculum development, short- and long-term training, and strategies to increase the number of minority professionals in gerontology.

A major potential breakthrough was achieved for minority contractors under the title IX Older American Community Service Employment Act. Both the House and Senate Appropriations Committees included report language for the fiscal 1977 Labor-HEW Appropriations Act to make it clear that the Congress expected the Department of Labor to enter into contracts with organizations serving the minority elderly. The Senate Appropriations Committee said:

> . . . the committee is anxious for the Department [of Labor] to enter into contracts with organizations such as those serving black, Spanish-speaking, and other minority groups seeking to operate jobs for the elderly programs.[5]

Similar language was included in the House report.[6]

Another employment development included the title X job opportunities (Public Works and Economic Development Act) grant to NCBA for $98,000 to hire 10 middle-aged and older workers (aged 45 to 64) to provide transportation-escort services to 2,000 persons in Springfield, Mass. The purpose is to protect elderly persons from being victimized by criminals.

In addition, NCBA is one of five national contractors (including National Council of Senior Citizens, National Council on the Aging, National Retired Teachers Association-American Association of Retired Persons, and National Famers Union) to develop employment programs for older workers for the Environmental Protection Agency under an interagency agreement between EPA and AoA. NCBA plans to develop employment programs with a focus on community beautification and sanitation.

Representatives from four minority groups [7] met for the first time at a gerontological society meeting with representatives from Federal agencies to address some of the problems affecting research on the minority elderly. Dr. Robert Butler, Director of the National Institute on Aging, served as chairman of the meeting, which was held in New

[5] S. Rept. 94-997 to accompany H.R. 14232, "Departments of Labor and Health, Education, and Welfare, and related agencies appropriations bill, 1977," 94th Cong., 2d Sess., June 26, 1976, pp. 13-14.

[6] H. Rept. 94-1219 to accompany H.R. 14232, "Departments of Labor, and Health, Education, and Welfare, and related agencies appropriations bill, 1977," 94th Cong., 2d Sess., June 8, 1976, p. 8.

[7] The representatives of the four minority groups included Dolores A. Davis (executive director for the National Center on the Black Aged, Washington, D.C.), Carmela G. Lacuro (national executive director for Asociacion Nacional Pro Personas Mayores, Los Angeles, Calif.), Masato Inaba (principal for the Human Resources Corp., San Francisco, Calif.), and Rachel Essandoh (trustee for the Native American Elders United, Carson City, Nev.).

York City on October 17. The minority groups have now formed a coalition to continue working with Federal agencies by recommending nominees to serve on peer review advisory boards and research priorities for the minority elderly.

B. Significant Steps for Older Native Americans

The first National Indian Conference on Aging was held in Phoenix, Ariz., June 15 to 17, 1976. Sponsored by the National Tribal Chairman's Association and funded principally by the U.S. Administration on Aging (AoA), this gathering brought together more than 1,000 Indian and Alaskan Native people representing 171 tribes. Participants attended sessions and workshops on income, environment, legal problems, physical well-being, and legislation. A summary of the conference, containing the recommendations of all workshops, was issued in November 1976.[8]

This conference presented an unprecedented opportunity for Indian elders to meet on immediate and long-range issues. An August follow-up meeting of the National Indian Task Force on Aging in Tulsa, Okla., voted to incorporate as the National Indian Council on Aging. The council received a 3-year grant from the AoA on September 30, 1976, and appointed Mrs. Juana Lyon as its executive director. This grant will provide the council with $242,367 in fiscal year 1977 for development of its organizational structure and activities; the grant amounts for the subsequent 2 years should be about the same amount.[9] The council will pursue the recommendations of the conference through advocacy for changes in legislation, service provider policies and regulations, as well as through intercession on behalf of individual tribes where appropriate. Council officials met in Washington with representatives of Federal agencies involved in Indian services; and legal counsel has been retained to provide expertise and liaison in the Nation's Capital.

INDIAN HEALTH CARE IMPROVEMENT ACT

The first significant action taken by the council was to urge White House approval of the Indian Health Care Improvement Act, S. 522. This legislation was enacted as Public Law 94–437 on September 30, 1976. It resulted from a congressional finding that:

> . . . the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. . . . All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.[10]

Specifically, the Congress found that further improvement in the health status of Indians was hampered by inadequate, outdated, inefficient, and understaffed facilities, and was further exacerbated by a lack of access due to poor communications and transportation and by

[8] Summary report, National Indian Conference on Aging, available from the National Indian Council on Aging, P.O. Box 2008, Albuquerque, N. Mex. 87103, $2.
[9] Conversation with Sandra Fisher, Office of Special Projects, AoA, Feb. 8, 1977.
[10] This language is contained in Sec. 2 (d) and (e) of Public Law 94–437.

a shortage of potable water and sanitary waste disposal facilities. The act declares it to be the national policy to provide a level of health services adequate to provide the highest possible health status to Indians. To this end, it authorizes the following appropriations for the recruitment and education of Indian health professionals, the expansion of health services, the construction and renovation of service facilities, and for the establishment of programs to meet the medical needs of Indians residing in urban areas:

AUTHORIZED APPROPRIATIONS UNDER PUBLIC LAW 94-437, THE INDIAN HEALTH CARE IMPROVEMENT ACT

[Fiscal years]

Title and program	Authorized appropriations (millions)		
	1978	1979	1980
Title I—Indian Health Manpower:			
Health professions recruitment program	$0.9	$1.5	$1.8
Health professions, preparatory scholarship program	.8	1.0	1.3
Health professions scholarship program	5.45	6.3	7.2
Indian health service extern programs	.6	.8	1.0
Continuing education allowances	.1	.2	.25
Title II—Health services:			
Patient care	(1)	8.5	16.2
Field health	(1)	3.35	5.55
Dental care	(1)	1.5	1.5
Mental health	(1)	3.4	5.075
Maintenance and repair	(1)	3.0	4.0
Alcoholism treatment and control	4.0	9.0	9.2
Title III—Health facilities:			
Hospitals	67.18	73.256	49.742
Health centers and stations	6.96	6.226	3.72
Staff housing	1.242	21.725	4.116
Safe water and sanitary waste disposal facilities	43.0	30.0	30.0
Title V—Health services for urban Indians:			
Contracts with urban Indian organizations	5.0	10.0	15.0
Rural health projects	Not more than 1 percent of the annual authorized appropriations for title V are available for 2 pilot outreach programs for Indians residing in rural communities near reservations.		

[1] All programs except Alcoholism share $10,025,000 in fiscal year 1978.

Note: For titles I, II, and III, there are authorized to be appropriated, for fiscal years 1981-84, such sums as may be specifically authorized by an act to be enacted in the future.

The act also provides for the reimbursement of eligible facilities through the medicaid program.

CLARIFICATION NEEDED ON CATEGORIES

The Indian and Native Alaskan populations of the United States now fall into three broad legal groupings:

(a) Federally recognized tribes and Alaska regional corporations whose members may reside on reservations or other trust land, in rural nonreservation areas, or in urban centers;

(b) Indian tribes or groups recognized as such by a State with members residing on State-recognized reservations, in rural nonreservation areas, or in urban centers; and

(c) Individuals not falling into categories (a) or (b) but nevertheless claiming to be of Indian descent or heritage.

As seen by participants at the Phoenix Conference, the importance of these distinctions lies in the fact that only individuals within category (a) are generally entitled to certain services of the Federal Government. Those benefits are based upon specific commitments made

in treaties, laws, and Executive orders, giving substance to the status of federally recognized tribes as quasi-autonomous sovereign entities whose relationship with the central Government takes precedence over the laws of individual States.

Indian individuals falling within categories (b) and (c) depend for their services primarily upon the States, counties, and cities within which they reside. Generally, their eligibility for such services is determined by the same criteria as are applied to the non-Indian populations. While protests about the inequity of the distinctions between federally recognized and other Indians were voiced at the conference, its summary report makes no recommendation as to a resolution and suggests that affected individuals work for a solution through the appropriate judicial and legislative avenues.

A desire for the direct funding of tribes to carry out programs on behalf of elderly Indians was also voiced repeatedly at the Phoenix conference. A step in that direction was taken by AoA in May 1976. An information memorandum [11] issued at that time requires each State with federally recognized tribes within its boundaries to submit an action plan for serving elderly Indians as part of its State plan. The action plan must insure that elderly Indians will receive a level of services under title III of the Older Americans Act that provides benefits equivalent to those received by non-Indian elderly. If the Commissioner determines that this is not the case, and that tribal members would be better served by a direct grant, the Commissioner shall reserve from sums that would be otherwise allotted to such State for area planning and social services 150 percent [12] of an amount which bears the same ratio to the State's allotment as the population of affected Indians over 60 bears to the total State population aged 60 and older. In a question-and-answer session at the Phoenix conference, AoA Commissioner Arthur Flemming stated that he believed this equivalency ratio should be extended to include title VII (meal program) activities.

The extension of present policy will not, however, meet the objections which have already been voiced by both tribal and State officials. Indian representatives have expressed the opinion that this allocation of State funds fails to grant recognition to their sovereign status, is administratively cumbersome where tribal residence extends beyond a single State's boundaries, and will benefit large tribes more than small ones.

Some State officials have told the committee that this new policy could cripple current aging programs. For example, direct funding for the 10.6 percent of Arizona's 60-plus population comprised of Indians would mean a 15.9 percent reduction in present State aging funds. These officials also note that the absence of service delivery to Indians often results from a tribe's refusal to deal through the State agency as an assertion of sovereignty. Arizona would have no objection to direct funding if the dollars are not taken from the present State aging budget.[13]

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[11] AoA–IM–76–62, May 3, 1976, attachment D.

[12] A range of 100–150 percent for this situation is required by the 1975 amendments to the Older Americans Act; see 42 U.S.C. 3001, title III, sec. 303(b)(3)(A).

[13] Conversation with Bob Thomas, acting bureau chief, Arizona Department of Economic Security; R. Allee Drought, director, Area Agency on Aging; and Lloyd Brown, assistant director, program services division, Arizona Department of Economic Security; Phoenix, Ariz., June 17, 1976.

OTHER DEVELOPMENTS

In May 1976, a revised statement of understanding concerning the improvement of services to elderly American Indians was issued.[14] The original agreement had been initialed by AoA and the Office of Native American Programs in October 1975. The revision added four signatories: The Indian Health Service, Public Services Administration, Office of Indian Education, and Department of Transportation. The document commits the six participating agencies to the promotion of better services through expansion of the base of knowledge about elderly Indian needs; the testing of new service modes; the expansion of public awareness; the enlargement of direct tribal and Indian organization involvement; an increased number of Indian professionals in service delivery; and a greater commitment of monetary and personnel resources.

Native American Elders United began to function in 1976. This organization was incorporated the previous year as an outgrowth of the National Council on the Aging's American Indian Caucus. Its purpose is the promotion of a better life for older Indians through the gathering of basic data, the dissemination of information to the general public, and direct appeals to all levels of government. The first step toward this goal was the mailing of a questionnaire to almost 500 tribes asking for identification of the needs and problems of the elderly. NAEU also publishes a quarterly newsletter.[15]

Committee on Aging hearings have included testimony on the need of older Indians. For example, at an August 18 hearing on "The Rural Elderly" in Sious Falls, S. Dak., Senator Dick Clark listened to testimony by Jack Claymore,[16] project director at the Cheyenne River Reservation in Eagle Butte. Mr. Claymore has developed a new form of long-term care facility for invalid Indians. His manor house concept provides efficiency apartments and supportive services-on-reservation for Indians who would otherwise have to be placed in distant nursing homes. This enables the residents to obtain vital services, avoid isolation, and remain close to familiar cultural roots.

C. Increased Activity by Spanish-Speaking Elderly

The Asociacion Nacional Pro Personas Mayores undertook new initiatives in its second year of existence.[17] The asociacion's funding base is a 2-year model project grant under section 308 of the Older Americans Act. The 1975 amendments made improved service delivery to limited English-speaking individuals a priority item for this grant category. The asociacion, during its first year of operations, established five regional offices—in Los Angeles, Albuquerque, Miami, New York, and the District of Columbia—to facilitate its policy of working at the local level to improve service delivery. With that organizational base now established, the asociacion is attempting to involve communities of the Spanish-speaking elderly in programs on aging. The

[14] AOA–IM–76–67, May 10, 1976.
[15] Interested persons may contact Native American Elders United by writing to 808 Ivy Street, Carson City, Nev. 89701.
[16] "The Nation's Rural Elderly," part 5, Aug. 18, 1976. Hearing not printed yet.
[17] See *Developments in Aging: 1975 and January–May 1976*, p. 180, for a description of the founding of this organization.

asociacion also sponsored the "First Western Regional Conference on Aging" held in October in Los Angeles, and has continued to appear before State and Federal bodies looking into the needs of older persons.

AoA has been working in other ways to improve delivery of services to Spanish-speaking elderly. A model "peer counseling" project has been started in the East Harlem section of New York City. Its aim is to provide part-time employment and on-the-job training to Hispanic-Americans interested in gerontology, while at the same time giving recipients counseling and developing a bilingual service model.

AoA, however, is still severely limited in its basic research in regard to the Spanish-speaking elderly. Only a single study was undertaken in 1976, and the results of this survey of Denver's Chicano elderly have yet to be evaluated. AoA will require accurate information to respond to the increased demand for services likely to result from the asociacion's community awareness and organizing efforts.[18]

D. The Pacific-Asian Elderly Research Project

On September 1, 1976, the Pacific-Asian Elderly Research Project (PAERP) was awarded a $131,561 grant from AoA for its initial year of operation.* Preliminary planning meetings have determined that PAERP will initially review existing data and attempt to compile needed additions. PAERP will then design a research program aimed at developing and testing service-delivery models. PAERP's goal is to create social and health services which can be effectively utilized by and are responsive to the needs of the Pacific-Asian elderly community.

PAERP has assembled a 15-member national resource committee intended to be representative of the geographic and ethnic distribution of Asian-Americans. This committee has been assigned four principal functions: (1) advising the project on the development of appropriate content, direction, and methodology; (2) analyzing and evaluating data developed by the project; (3) providing liaison and feedback between the project and the community; and (4) planning a national conference for the presentation of the project's conclusions. This national conference will then formulate a strategy for implementing improved social programs based on the data and service models developed by the project.

PAERP held its initial meeting in Los Angeles in December 1976.**

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[18] Information in this section obtained from a conversation with Gil Colon, Assistant to the Commissioner, AoA, Dec. 6, 1976; and from volume 1, Nos. 1 and 2 of the newsletter of the Asociacion Nacional Pro Personas Mayores, 3875 Wilshire Boulevard, Suite 401, Los Angeles, Calif. 90005. It should be noted that Mr. Colon, a former HEW fellow, is a native of Puerto Rico and the first Hispanic to hold his post.

*PAERP developed out of the Asian-American Mental Health Research Center's ad hoc task force on aging. The center was started by Asian-American social service workers and community representatives, and is governed by an advisory board composed of elected representatives from nine national regions. The center received its initial funding from a 1974 National Institute on Mental Health grant.

The center has established five priority research areas: immigration; aging; economic conditions, especially underemployment; negative stereotypes; and the delivery of medical and mental health services. It has received additional small grants from various units of Federal and State government.—Information from a conversation with Dr. William Liu, director, Asian-American Mental Health Research Center, 1640 W. Roosevelt Road, Chicago, Ill. 60608, on Feb. 18, 1977.

**Information in this section was obtained from Mrs. Victorina Peralta, director of adult services, Philadelphia Department of Public Welfare. Mrs. Peralta was chairwoman of the task force on Asian aging and is presently a member of PAERP's national resource council. Further information about PAERP may be obtained from Sharon M. Fujii, principal investigator, 2400 South Western Ave., No. 206, Los Angeles, Calif. 90019.

E. Looking Ahead Toward the 1985 Mid-Decade Census

The first mid-decade census is scheduled for 1985. It holds out the possibility of timely updating of basic data about Americans while at the same time permitting a breadth of questioning beyond that of the regular census. The Special Committee on Aging believes that the mid-decade census will offer an excellent opportunity for increasing our knowledge of the status of older Americans, particularly minority elderly. It plans to consult with demographic experts and with minority senior representatives with a view toward submitting suggested questions to the Bureau of the Census. Planning for the mid-decade census is scheduled to be finalized during 1980.

CONCLUSIONS

The economic deprivation of elderly minority groups has intensified because of the 1974–75 recession. By whatever barometer one would use, their quality of life is less satisfying than that of aged whites. Major policy changes are needed to improve the economic well-being of aged blacks, Spanish-speaking persons, Indians, and Asian-Americans.

The committee recommends that the income standards for the SSI program be raised to a level to eliminate poverty for the elderly.

Additionally, the committee urges:

—The Department of Labor to take prompt action to assure that national organizations representing the minority elderly are actively involved in the administration of title IX senior community service employment projects.

—The Department of Housing and Urban Development to make more section 202 housing for the elderly loans to minority sponsors.

—The Administration on Aging to continue its efforts to involve minority organizations more actively under Older Americans Act programs.

In 1977, the committee plans to undertake a major examination of the treatment of minority groups under social security. Moreover, the committee plans to focus on their special needs in other areas as well: Employment, services, health, housing, and others.

II. ADMINISTRATION OF SSI

The supplemental security income program (SSI) was in its second full year of operation during 1976 and was still troubled with administrative difficulties, including:

—Overpayments;
—Payments to ineligible applicants;
—Underpayments;
—Delays in processing applications, hearings and appeals; and
—Failures to reach potential recipients.

The SSI quality assurance system was developed by the Social Security Administration in 1975 to measure the payment efficiency of the

SSI program. It analyzes pertinent data and reports on payment efficiency every 6 months. The last such account showed:

NATIONAL SSI PROGRAM QUALITY STATUS REPORT

[Percent of cases with payment inaccuracies]

	July to December 1975 [1]	January to June 1976 [1]	January to June 1976 on new basis
Overpayments	9.9	9.4	7.7
Payments to ineligibles	8.1	7.8	6.5
Subtotal	18.0	17.2	14.2
Underpayments	6.1	5.6	4.9
Total	24.1	22.8	19.1

[1] According to definition of "case error" presented in previous SSI reports (includes payment adjustment lag cases).

[In percent]

Incorrect payments	Agency-caused		Beneficiary-caused		Totals	
	Case	Dollar payment	Case	Dollar payment	Case	Dollar payment
Overpayments	4.8	2.2	2.9	1.2	7.7	3.4
Payments to ineligibles	2.5	1.8	4.0	3.0	6.5	4.8
Subtotal	7.3	4.0	6.9	4.2	14.2	8.2
Underpayments	2.8	(1)	2.1	(1)	4.9	(1)
Totals	10.1	4.0	9.0	4.2	19.1	8.2

[1] Dollar underpayments are not calculated since they do not represent dollars expended. The SSI payment process automatically corrects reported underpayments once they are identified.

SUMMARY OF DOLLAR VALUE OF OVERPAYMENTS

	January to June 1975	July to December 1975	January to June 1976	January to June 1976 on new basis
Total SSI payments (including federally administered supplements) (in billions)	$2.8	$2.9	$3	
Dollar value of overpayments as extrapolated from QA data (in millions)	$321	$315	$300	$24
Percentage of overpayments to total payments	11.5	10.9	10.1	8.2

Note: All tables are from data contained in a letter of Nov. 22, 1976, from the Commissioner of Social Security, James B. Cardwell, to Senator Frank Church, chairman, U.S. Senate Committee on Aging.

Many of the errors caused in administering SSI cannot entirely be contributed to human or computer error. According to a recent General Accounting Office (GAO) report,[19] the principal factor involved in the erroneous payments is the inability of the Social Security Administration to secure accurate and total information on compensation and pension income received by SSI recipients. As such data—other income from such compensation and pension programs—is pertinent information upon which the SSI recipients payment level for SSI is determined, inaccuracy in tabulating the potential recipi-

[19] Report to the Congress by the Comptroller General of the United States, "Supplemental Security Income Payment Errors Can Be Reduced," Nov. 18, 1976.

ent's actual payment amount from such pensions will result in overpayments, underpayments, or even payments to ineligible persons. According to the GAO report:

> GAO estimates that if the Social Security Administration had accurate Veterans Administration and Railroad Retirement Board benefit information, supplemental security income overpayments would be reduced by $60 million a year; the Nation's needy aged, blind, and disabled would receive an additional $4 million a year to correct present underpayments; and 35,600 recipients would be removed from the supplemental security income rolls, with associated reductions in administrative costs and medical assistance payments under medicaid.[20]

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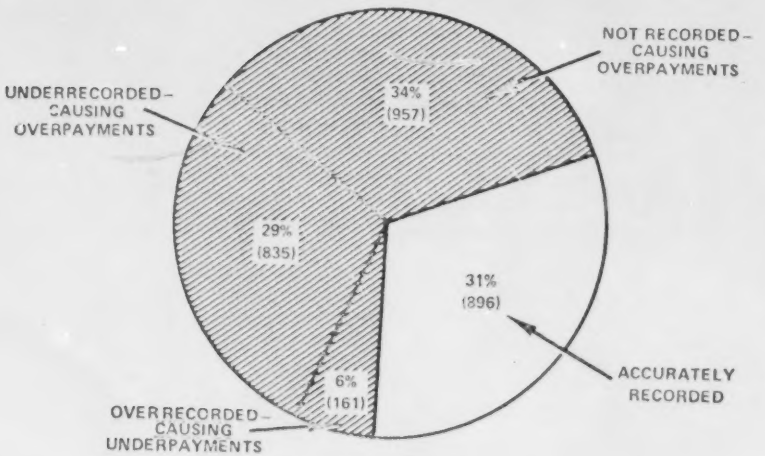
[20] Reference cited in footnote 19.

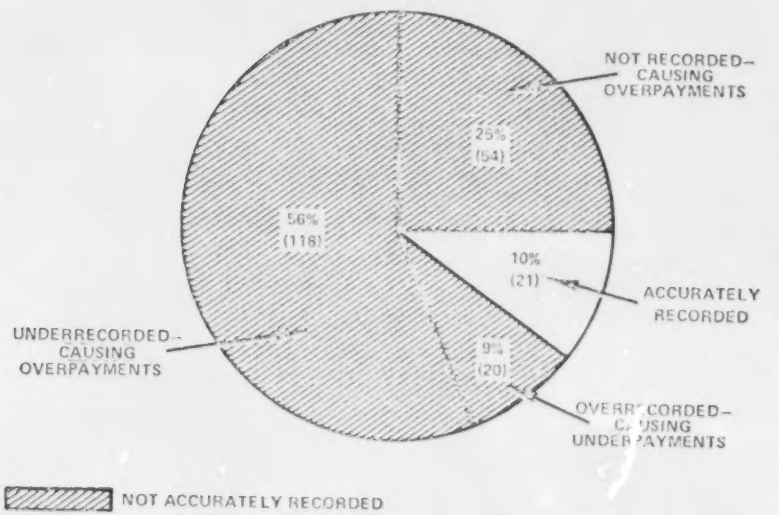
VETERANS ADMINISTRATION BENEFITS

(2,849 cases)



RAILROAD RETIREMENT BOARD BENEFITS

(213 cases)



NOT ACCURATELY RECORDED

GAO recommended the following:

That the Department of Health, Education, and Welfare obtain accurate and complete compensation and pension income information on a timely and continuing basis from the Veterans Administration and the Railroad Retirement Board for computing SSI payments;

That the Department of Health, Education, and Welfare review other Federal benefit payments to SSI recipients, such as Civil Service Commission retirement benefits, to determine the need for and feasibility of obtaining benefit information from other agencies; and

That DHEW establish, where appropriate, a system to insure that information on benefits paid to SSI recipients by Federal agencies will be obtained on a timely and continuing basis for future payment computations.

HEW agreed with the recommendations of the GAO and is taking preliminary steps to carry out the necessary actions. In addition, the Veterans Administration and the Railroad Retirement Board have agreed to work cooperatively with the Social Security Administration to put forth more accurate data.

Inaccuracies in one's level of other compensations and pensions in determining SSI benefits, often leads a person to believe that the applicant has deliberately given false information to the interviewer. For SSI purposes, this has been found to be untrue in the majority of cases. In a study by the Social Security Administration and Temple University the researchers state that their data suggests that "to the extent that unreliability and invalidity exist, its cause is not the desire of the SSI recipient to obtain payments for which he is ineligible." [21]

The major source of income for most SSI recipients is "unearned income" such as social security, veterans, railroad retirement, civil service benefits, and so forth. Only about 10 percent of SSI recipients have "earned income" from employment. Therefore, the major bulk of data on income regards the unearned income figures, and the inaccuracies of these figures lead to the errors in payments. This is not to imply that everyone who receives SSI is totally and undeniably honest in their presentation of their income and resources status. However, research has shown that fraud among welfare programs has always been less in "aged categories" and the presence of such fraud by the recipient in SSI has been minimal. But like the Social Security Administration and Temple University study states, "The serious concern about welfare, and in particular SSI, should not be that of the recipient cheating the system, but the system failing to service those for whom it exists." [22]

III. UTILITY COSTS

In a Senate speech last spring, Committee on Aging Chairman Frank Church described the awesome upward spiral of fuel and utility costs since 1973, and the particularly devastating impact this has had upon older Americans trying to survive on fixed and meager incomes:

[21] "The Aged Poor: Are They Welfare Chiselers?" a study of reliability and validity of response in the SSI redetermination process, by John J. Cabouch, Ph. D., Director of Communications, Planning and Evaluation, Office of Information, Social Security Administration, and Leonard A. Losciuto, Ph. D., director, Institute for Survey Research, Temple University.

[22] Reference cited in footnote 21.

Fuel and energy costs have increased at nearly double the overall inflationary rate during the past 2½ years. From August 1973 to February 1976, the Consumer Price Index rose by almost 24 percent.

Fuel and utility costs, however, leaped forward by 41 percent.

Home heating fuel oil increased by an astonishing 82 percent during the past 2½ years. Other sources of energy also rose at an accelerated pace: Natural gas for heating homes by 51 percent and electricity rates by 38 percent. . . . An elderly person living on a $202 monthly social security check—and this is the average benefit for a retired worker—does not have the sufficient margin between income and outgo to withstand higher energy prices.

These points were also confirmed in a recent study for the Federal Energy Administration. That study included these major findings:

The elderly poor consume less energy than other age groups but spend a much higher proportion of their income for energy-related expenditures.

The aged poor's energy costs are primarily for everyday necessities—such as cooking and heating—rather than discretionary luxury items.

The elderly poor pay a higher per unit cost for electricity and natural gas than other income groups.

In addition, health care problems intensify the energy cost squeeze for older Americans. Nearly 85 percent of the non-institutionalized aged have at least one chronic condition. This not only increases their medical costs but also their ability to absorb rising energy prices. It may, moreover, affect their tolerance for adjusting room temperatures to reduce their energy costs.[23]

Senator Church proposed the Energy Savings Demonstration Act, authorizing funding for the testing of innovative methods designed to make energy costs more equitable and less burdensome. Some of those ideas were later enacted as part of legislation continuing the Federal Energy Administration (FEA); that bill contained additional provisions, such as a weatherization program for low-income persons, which are of potential benefit to elderly consumers.

But, in the meantime, executive branch regulatory bodies made decisions which will increase utility bills. And the unusually cold winter of 1976–77 caused a further increase in the Nation's energy bill and emphasized the continuing need for a reexamination of national energy policies.

A. The FEA Bill—A Forward Step

In August 1976 Congress extended the life of the controversial Federal Energy Administration (FEA) while reserving decision on whether its responsibilities and existence should continue beyond the end of 1977.[24]

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[23] Congressional Record, vol. 22, No. 64, May 4, 1976, p. S 6398.
[24] Public Law 94–385, enacted August 14, 1976.

This Energy Conservation and Production Act will facilitate congressional and executive energy policymaking through the establishment of an Office of Energy Information and Analysis within FEA. Its task is to compile the basic data about energy supply and consumption which takes place within or affects the United States.

The act also contains several provisions of potential benefit to consumers:

—The FEA Administrator is directed to develop and submit to Congress proposals for improved electric rate designs which encourage conservation, minimize the need for new generating capacity, and lower consumer costs.

—The FEA Administrator is authorized to fund demonstration projects which improve load management procedures and promote rate reform.

—The FEA Administrator is given authority to intervene in a rate proceeding at the request of a State, regulatory commission, or any proceeding participant; and to intervene in the judicial review of such an administrative hearing if a similar request is made.

—The FEA Administrator is authorized to award grants to States for the establishment and operation of offices of consumer services which will provide representation for consumers in regulatory proceedings.

—The FEA Administrator is directed to develop a weatherization assistance program for low-income persons, with the elderly and handicapped receiving priority treatment. While most of the grants will be channeled through State and community action agencies, direct grants to Indian tribes are permitted.

Unfortunately, there have been delays in implementing these provisions. The proposals for improved rate designs had not been submitted by the due date of February 14, 1977. However, John F. O'Leary, the new FEA Administrator, made a commitment to send these proposals to Capitol Hill by February 24 during his confirmation hearings.[25] The regulations for the weatherization program were also overdue; although Congress had mandated that they be issued in November 1976, they are not expected to be published in final form in the *Federal Register* until sometime in March 1977. The Administration on Aging, after reviewing the proposed weatherization regulations, submitted substitute language to the FEA in December which it felt could improve the regulations' ability to carry out the congressional intent that older persons receive priority treatment.[26]

The FEA had been funding some load management demonstration projects even before its life was extended, and has been intervening in State regulatory hearings on a regular basis. However, it has had difficulty in expanding these activities because its last appropriations were passed in July and did not contain funds for the new programs.

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[25] All the information about the status of FEA regulations and programs within section A is from a conversation with Margot Hastings, legislative specialist, FEA, Feb. 15, 1977.

[26] Conversation with Eric West, program analyst, Office of Planning and Evaluation, AoA, Feb. 15, 1977.

Its request for supplemental funding for fiscal year 1977 and for fiscal year 1978 does earmark dollars for them and should be acted upon by the Congress by April 1977.[27]

B. The FPC Natural Gas Price Increase

Natural gas which is designated for interstate shipment is subject to a maximum wellhead price [28] set by the Federal Power Commission (FPC). The price history of this energy source is illustrative of the inflation which has faced America's consumers. The wellhead price stood at about 20 cents per thousand cubic feet through the 1960's, was boosted from 26 to 42 cents per thousand cubic feet in June 1974, and was subject to a maximum charge of 52 cents at the start of 1976. A General Accounting Office (GAO) study made at that time concluded that the price of natural gas would continue to rise whether or not it was deregulated.[29] In July the FPC did not deregulate natural gas but rather raised the permissable price for gas brought into production after 1974 to near the prevailing intrastate rate.[30] This was the largest interstate gas price boost in history, a 184 percent leap to $1.42 per thousand cubic feet.

The FPC justified this increase as providing a needed incentive for the exploration of new gas reserves and their dedication to the interstate market. The gas shortage brought about by the extremely cold winter of 1976–77 demonstrated the desirability of such a result. However, the FPC did not require that profits realized by the producers from the increase be invested in new exploration.

The FPC action has elicited challenges in both the courts and Congress. Initial court challenges did not secure a repeal of the boost but merely the requirement, never imposed by the FPC, that producers refund any portion of the increase subsequently held illegal.[31] According to a staff study of the House Subcommittee on Oversight and Investigation, such an eventual determination is possible. They charged that the FPC was the "worst" of the nine major Federal regulatory bodies and that some of its members had "consciously disregarded" and "mismanaged and betrayed" their duty to protect consumers.[32] After further study, that same staff concluded that the $1.42 price was based on unverified, industry-generated data and that

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[27] Although the FEA does now have authority to fund rate demonstration projects, Senator Church reintroduced the Energy Savings Demonstration Act on Feb. 10, 1977 (S. 686, Congressional Record, pp. S 2481–3). This bill differs from the FEA's present authority by requiring the FEA Administrator to fund such projects rather than being merely permissive; by being more detailed in regard to eligibility, evaluative criteria, and regulatory development; and by increasing the available funding. In addition, S. 686 contains language which would expand the authority of the FEA Administrator by permitting him to provide financial assistance to State regulatory commissions, State and local governments, and nonprofit corporations for the purpose of studying alternate financing schemes such as emergency grants, loans, and deferred payment schedules which could assist financially pressed consumers.

[28] The wellhead price is the price which the owner of the well charges to a pipeline company.

[29] Implications of Deregulating the Price of Natural Gas, report to the Committee on Government Operations, House of Representatives, by the Comptroller General of the United States, GAO Report No. S–76–05670, Jan. 14, 1976.

[30] FPC Opinion 770, July 27, 1976.

[31] Washington Post, Aug. 10, 1976, p. D7.

[32] Washington Post, Oct. 18, 1976.

countervailing and more reliable information within the FPC's possession indicated that a reasonable and lawful price would be in the range of 46 to 55 cents per thousand cubic feet.[33]

The FPC's response to such criticism was an admission that its original estimate of increased consumer costs of $1.5 billion understated the true effect of the price boost by half a billion dollars, and that it would therefore reduce the price. But that reduction was not accomplished by lowering the thousand cubic foot rate but by redefining "new gas" so that producers could not realize the higher rate by sinking new drills into old wells. And the Wall Street Journal, after studying the same data on which the FPC based the increase, projected that the actual cost to consumers would be up to $4 billion, or $45 per household.[34]

The natural gas shortage of this past winter has dramatically illustrated the need for a new look at national policy. President Carter's initial energy pronouncements indicated that he might favor a mixture of deregulation, allocation controls, verifiable industry data, conservation, and financial assistance for poorer households. It should also be noted that, during his campaign, he advocated the dissolution of the FPC and the transfer of its regulatory powers to a new cabinet-level Department of Energy.[35]

C. Deregulation of Other Fuels

Natural gas was not the only form of energy to rise in price during 1976:

—In April the price of residual fuel oil was deregulated. Electric power is usually produced from this fuel, and the price increase is passed along to consumers of electricity.[36]

—In April the FEA also instituted an "entitlements program" to eliminate a competitive situation in the northeast which it felt was unfair. The program transfers funds between refiners and, while accomplishing its purpose, had the side effect of raising the price of oil reaching northeastern refineries by $1 per barrel.

—In July, the price of No. 2 home heating oil was decontrolled. By September, the price of this fuel in the New York City area had risen to 41 cents per gallon, compared to 38 cents a year earlier and 22 cents prior to the 1973 oil embargo.[37] This near doubling of energy costs in a 3-year period is illustrative of the unprecedented price rises which are putting the cost of heat and light out of the reach of many elderly and other low- and fixed-income groups.[38]

D. FAC's: Invisible Inflation

Automatic Fuel Adjustment Clauses (FAC's) are provisions in utility company rate schedules which allow the pass-through to consumers of changes in the cost of fuel from suppliers.

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[33] The Productivity Factor in FPC Opinion 770, staff study by the House Subcommittee on Oversight and Investigations, Oct. 31, 1976.
[34] Wall Street Journal, Oct. 20, 1976.
[35] National Journal, Nov. 13, 1976, p. 1630.
[36] The FEA was given the authority to decontrol fuel supplies by the Energy Policy and Conservation Act, Public Law 94-163. The action takes effect 15 days later unless the House or Senate, by a majority, vetoes it.
[37] New York Times, Sept. 23, 1976.
[38] Information in this section from a conversation with Tom Greene, counsel to the chairman, House Subcommittee on Oversight and Investigations, Nov. 11, 1976.

83-453 O - 77 - 12

Two Senate subcommittees undertook an investigation of the effect and operation of FAC's after they received information that electric and gas utility bills had increased $9.6 billion in 1974.[39] *This sum was equivalent to 150 percent of all the rate increases which had occurred during the preceding quarter century.*

They found that utility bills had leapt an additional $12.6 billion in 1975, with FAC's accounting for more than two-thirds of the increase.[40] These findings prompted Senators Muskie and Metcalf to state, in their introduction to the investigative report:

> The continuing high rates of return on equity by utilities, and the record rate increases documented in this report, suggest utility customers may be bearing a disproportionate share of the increased costs of energy.

They also noted that the 94th Congress had taken two actions which could help utility customers. The first was the rejection of President Ford's proposal that FAC use be mandated for all State and Federal commissions. That would have expanded even further the percentage of energy cost increases which go unscrutinized by regulatory bodies and fail to be reported by the utility industry or the FPC. The second action was the provision authorizing the establishment and operation of offices of consumer services in the FEA bill (described in section A). These offices will assist consumers in presenting their side of the story to regulatory bodies.

E. Other Developments

Weatherization programs can significantly reduce the utility bills of low-income persons. The Community Service Administration has already been operating such enterprises such as Operation Open City in New York. It puts the unemployed to work insulating the homes and apartments of poverty-level persons; the New York State Division of Economic Opportunity underwrites most of the labor costs. Recipients have included a 70-year-old SSI recipient in the South Bronx who had an astounding annual fuel bill of $1,200. Operation Open City has been hampered by a $125 limit on materials per dwelling; the new Federal weatherization program will raise that ceiling to $400.[41]

The lifeline utility concept, which would guarantee each household a basic utility supply at a minimal rate, began to be implemented in California. A State plan there froze the price of lifeline quantities for residential gas and electric; the freeze will continue until the rates for commercial and nonlifeline residential use rise in excess of 25 percent.[42] However, voters in Massachusetts and Ohio rejected lifeline referenda in the November 1976 elections.[43]

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[39] "Electric and Gas Utility Rate and Fuel Increases, 1975," GPO stock No. 052–070–03645–1, September 1976; prepared by the Economics Division of the Congressional Research Service for the Senate Subcommittee on Intergovernmental Relations and on Reports, Accounting, and Management. This survey covers only investor-owned electric and gas utilities; these utilities produce approximately 80 percent of the electric and 94 percent of the natural gas used within the United States.

[40] The breakdown was as follows: Electric costs rose $9.2 billion, with $3.3 billion attributable to formal rate cases and $5.9 billion to FAC's. Natural gas rose $3.4 billion, with $0.8 billion due to rate cases and $2.6 billion to FAC's.

[41] New York Times, Nov. 7, 1976, p. 55.

[42] New York Times, Sept. 13, 1976.

[43] National Journal, vol. 48, No. 46, Nov. 13, 1976, p. 1642.

The bitter winter of 1976–77 depleted the natural gas supplies to dangerously low levels, closed factories throughout the Northeast and Midwest, and presented elderly persons living on fixed incomes with the prospect of unaffordable heating bills. The Senate originated several proposals designed to alleviate the immediate financial crisis of such persons and set up a system for meeting similar situations in the future.[44]

However, the avoidance of crises is preferable to alleviating their effects through humane legislation. That avoidance will depend on a coherent national energy policy based on reliable data and utilizing innovative rate structures, allocations of fuel based on their best use, and conservation. If higher energy prices are to be an inevitable feature of the future, a means must be devised to assist America's elderly in affording their basic needs of heat and light.

IV. CONSUMER PRODUCT SAFETY AND THE ELDERLY

An amendment to the Consumer Product Safety Commission Improvements Act[45] directs the Consumer Product Safety Commission (CPSC) to consider the special needs of the elderly and handicapped in the promulgation of any consumer product safety rule to determine whether they would be adversely affected by the rule.

A. Implementing the Church Amendment

The CPSC now requires an assessment to be made of the potential adverse effect of a specific safety rule on the elderly and the handicapped and has formalized a policy for setting priorities for action which take into consideration the vulnerability of special population groups, including the elderly and handicapped.

Two examples of the need for special consideration of the elderly and handicapped in setting safety standards follow:

"*Child-Proof*" *Packaging for Hazardous Substances.*—The Poison Prevention Packaging Act of 1970, now administered and enforced by the Consumer Product Safety Commission, provided for special packaging of household products and poisonous substances, such as drugs, which could cause serious injury or illness to children. Special packaging was defined as containers which would be difficult for children under the age of 5 to open. Recognizing that such well-protected containers could also be extremely difficult for many elderly and handicapped to open, however, the act also directed that consumers in households without small children be supplied with conventional containers upon request.

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[44] For example, on Feb. 9, the Senate Budget Committee voted to add $300 million to pay for any forthcoming program designed to assist the poor and elderly meet the increased fuel costs brought about by the winter. And on Feb. 11, Senator Williams introduced the Energy Crisis Relief Act, S. 726, which would establish a program of Federal relief for future energy emergencies (Congressional Record, p. S 2676–7).

[45] Public Law 94–284, enacted May 11, 1976. The amendment was introduced by Senator Frank Church and accepted by Senate and House conferees. See Developments in Aging: 1975 and January–May 1976, Part I, a report of the Special Committee on Aging, U.S. Senate Report No. 94–998, p. 190, for Senator Church's floor statement on the amendment.

But this particular provision of the law was not widely advertised. By the CPSC's own report, even many pharmacists were not aware of the exception until recently.[46] The Commission now reports that it is stepping up its information and education activities, particularly as they affect the elderly.

Matchbook Safety Standards.—Original standards proposed for matchbook safety also included a provision to make matchbook covers difficult for a child to open. In April 1976, however, this "child proof" provision was dropped in consideration of the difficulties which would be experienced by many elderly and handicapped persons. The proposed standards also require that the burning time for matches be of short duration, in part because CPSC research has shown that many elderly and handicapped tend to drop matches once they are ignited—a major cause of fire injuries and death.

The need for close attention to implementation of the Church amendment is evident. Although the Special Committee on Aging recognizes that establishing regulations or specific agency procedures to implement the amendment imposes additional responsibilities on the Commission—and commends the Commission for actions taken in setting safety standards for match books—it urges the Commission to consider implementing more formal controls in its standard-setting process to assure that these needs are continuously addressed. Assuring representation of the elderly and handicapped on CPSC citizen advisory panels could also help insure adequate attention to these needs. The committee also urges the Commission to undertake vigorous public education activities to assure that all elderly and handicapped are aware of special provisions which may affect their safety and well-being.

B. Setting Priorities for Safety Standards

Persons age 65 and over represent a population group particularly vulnerable to injury and death from home accidents and consumer products.

During 1976, injuries from falls associated with stairs and steps were the most frequently reported accidents among persons 65 years of age and over. Flooring material, chairs, and bathtub and shower structures also are the cause of many injuries for the elderly.[47]

Since promulgation of safety rules on the flammability of fabrics used in children's clothing, the Commission has found that the elderly still remain particularly vulnerable to burn injuries associated with clothing, particularly sleepwear and other loose-fitting garments. Twenty-seven percent of all burn injuries from such clothing occurred in the 64 years and over age group during 1976, although this age group represented only 11.3 percent of the population.[48] The Commission is considering fabric and design standards that would require more flame-retardant fabrics for loose-fitting designs such as nightgowns and bathrobes, but adoption of such an action will be more

[46] Committee staff communication with CPSC official, December 1976. In the meantime, however, some pharmacists offering the conventional packaging require customers to sign a waiver before selling a product without child-proof caps, causing complaints from some elderly consumers. According to the CPSC, the Commission does not have authority to restrict this activity.

[47] NEISS News, National Electronic Injury Surveillance System, U.S. Consumer Product Safety Commission, vol. 5, No. 1, July-August 1976.

[48] U.S. Consumer Product Safety Commission, 1976 annual report, October 1976.

difficult to implement than similar rules affecting children's clothing as the standard would have to apply to all adult clothing sizes.

A recent congressional evaluation of the activities of the CPSC has underlined the importance of a wise selection of priorities in the promulgation of safety standards, as the Commission estimates there are 10,000 consumer products within its jurisdiction.[49] This same evaluation recommended that the Commission develop a better capability to plan and set priorities than is now the case, and cited the CPSC's recent development of a policy on priorities as a step in the right direction.[50]

The Special Committee on Aging urges the Commission to give careful consideration to setting safety standards for fabric flammability in nightclothes, for bathroom fixtures, and for beds and mattresses in its priority list of specific products to be addressed.

The committee also urges the CPSC to institute procedures for involving other consumer education groups, particularly those serving the elderly, in the development and dissemination of safety information on products which come to their attention as having a special effect on the older population—particularly on conditions, such as safety on stairs and steps, which are hazardous areas for the elderly.

V. PRESCRIPTION DRUG PRICES

In May 1976, the U.S. Supreme Court issued a landmark decision concerning the advertising of prescription drugs. This decision has potentially far-reaching implications for older Americans. Regulatory action on prescription drug price disclosure—already in process at the time of the Court action—has been put in abeyance until more is known about the effect of the decision.

A. The Importance of Drugs to the Elderly

In 1975, Americans spent over $10 billion for drugs and drug sundries, representing a 10 percent increase over 1974.[51] Though older Americans comprise about 10 percent of the population, they accounted for 25 percent of the Nation's total expense for drugs.[52] Those over 65 spend nearly three times as much as the rest of the population per capita for drugs.[53]

As things now stand, medicare does not cover drugs on an outpatient basis. This means that the elderly pay for about 87 percent of their prescriptions from their own private sources.[54]

B. The Supreme Court Decision

In May 1976, the U.S. Supreme Court handed down a decision in the case of *Virginia State Board of Pharmacy, et al.* v. *Virginia Citizens*

[49] Federal Regulation and Regulatory Reform, report of the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, U.S. House of Representatives, October 1976.

[50] Page 240 of report cited in footnote 47.

[51] Mueller, Marjorie Smith and Robert M. Gibson, "National Health Expenditures, fiscal year 1975," Social Security Bulletin, February 1976, p. 7.

[52] Mueller, Marjorie Smith and Robert M. Gibson, "Age Differences in Health Care Spending, fiscal year 1975," Social Security Bulletin, June 1976, p. 19.

[53] *Ibid.* at 20. The average per capita expenditure for drugs by people 65 and older was $117.68 while the average for the rest of the population was $41.03.

[54] *Ibid* at 19.

Consumer Council, Inc., et al., 44 U.S.L.W. 4686. The Court declared unconstitutional a Virginia statute banning the advertising of prescription drug prices. This action makes many State statutes of dubious constitutionality.[55]

C. Federal Trade Commission Action

Prior to the May decision, the Federal Trade Commission received comments on two proposed trade regulation rules to remove all barriers to the free disclosure of prescription drug prices. Soon after the decision, the FTC suspended further action on those rules until the ramifications become more evident.

The FTC, for example, is investigating the impact of the decision on drug price disclosure. FTC field offices will monitor the situation of price disclosure now. In addition, they will contact potential advertisers to receive their reaction to the VCCC case.

The Supreme Court, however, did not focus on one important issue related to prohibition on drug price advertising—the private codes against disclosure that are held by many national and State pharmacy organizations. The FTC is also planning to examine the effect of these restraints on price disclosure to determine if any action is needed in this area. The proposed trade regulation rules would prohibit such private restraints.

The FTC investigation is scheduled to be completed by midspring and a decision on the trade regulation rules should come shortly afterward.

D. Other Activities

In November 1975, the Department of Justice filed a civil antitrust suit, charging the American Pharmaceutical Association with conspiring to prohibit the advertising of prescription drugs. The suit is pending in the U.S. district court in Grand Rapids, Mich.

E. The MAC Program

The Social Security Administration is administering a maximum allowable cost (MAC) program which sets maximum prices for payment of drugs under medicare and medicaid. Ampicillin is the first drug that has a proposed MAC limit which should be in effect in the early part of 1977. MAC requires the generic substitution of equivalents when available and will mean a considerable reduction in the cost to the Government for covered drugs. It is estimated that the savings on Ampicillin will be around $700,000 annually. Several other drugs will be subject to the MAC, which may be available during the first half of 1977.

VI. HEARING AIDS

Federal agencies continued to pay close attention to the hearing aid industry in 1976. The expressed intent of both the Food and Drug Administration and the Federal Trade Commission was to insure that

[55] The Federal Trade Commission has estimated that as many as 34 States have statutes or codes that present significant barriers to price advertising. "Prescription Drug Price Disclosures," staff report to the Federal Trade Commission, Jan. 28, 1975, p. 4.

consumer interests are properly represented in the selection and purchase of hearing aid devices.

A. FDA Action

On February 15, 1977, the Food and Drug Administration published final regulations to establish uniform professional patient labeling requirements and conditions for sale of hearing aid devices.[56]

The regulations, effective in all States on August 15, 1977, and applicable to all private sales transactions for hearing aids, would:

(1) Prescribe the types of information that must be included in the labeling to provide hearing health professionals and patients with adequate directions for the safe and effective use of a hearing aid.

(2) Specify the technical performance data that must be included in the labeling to assure that hearing health professionals have adequate information to correctly select and fit a hearing aid.

(3) Restrict the sale of a hearing aid to those patients who have undergone medical evaluation within the past 6 months, but with the provision that fully informed adult patients may waive the medical evaluation.

Generally, the rules met with enthusiastic support. The New York League for the Hard of Hearing, however, expressed reservations about the possible effect the rules may have on the role of audiologists in the process of selecting a hearing aid.

B. FTC Action

In a parallel effort, the Federal Trade Commission is continuing an investigation of the hearing aid industry. In June of 1975, the FTC had proposed trade regulation rules which:

(1) Provide that the seller must give the consumer the right to cancel his hearing aid purchase within 30 days and get most of his money back.

(2) Require that certain information be disclosed to consumers, including the fact that many persons with hearing loss will not receive any significant benefit from the use of any hearing aid.

(3) Prohibit the use of certain terms and selling techniques which might mislead or deceive consumers.

The period for public comment on these proposed rules has closed and the FTC staff is continuing their evaluation before final rules are issued.

VII. FTC ACTIONS ON FUNERALS

On August 29, 1975, the Federal Trade Commission proposed a trade regulation rule designed to elimizate what the FTC found to be industrywide unfair and deceptive practices in the funeral service industry.[57]

In 1976, the FTC proposals stirred widely contrasting reactions. As proposed, the trade regulation rule contains 23 separate provisions

[56] Federal Register, vol. 42, pp. 9285–9296, Feb. 15, 1977.

[57] *Funeral Industry Practices, Proposed Trade Regulation Rule and Staff Memorandum*, Division of Special Projects, Bureau of Consumer Protection, Federal Trade Commission, August 1975.

intended to lower the cost of funerals to individual consumers and provide more freedom of choice in funeral arrangements by requiring price disclosure and advertising for funeral items; by eliminating marketing techniques and devices which gain unfair leverage over consumers during a state of emotional distress; by requiring the industry to provide consumers with clear and full representations of State laws governing funerals; and by prohibiting any interference with the activities of others in offering low-cost funerals.[58]

Written comments on the proposed rule were accepted by the FTC through December 1975, and public hearings were conducted in six cities from April 20, 1976 through August 6, 1976 to obtain information from all interested consumers and members of the funeral industry.[59]

Support for the proposed rules during this comment and hearing period came from many individuals and organizations, including consumer groups, representatives of national organizations on aging, and members of the funeral industry:

Virginia H. Knauer, Director of the White House Office of Consumer Affairs, stated that her comments to the FTC were designed to "encourage the Commission to promulgate a trade regulation rule insuring maximum easily understandable information to consumers so that reasonable choices can be made regarding funeral services."[60]

Mrs. Knauer added that she agreed that price disclosure is necessary and "can be a forceful tool in destroying the all too pervasive myths which cloud the funeral purchase."[61]

The Office of Consumer Affairs urged the FTC to expand the rule to curb product misrepresentations made by distributors to funeral directors and to cemeteries and manufacturers of funeral artifacts. Mrs. Knauer also said that many States "practically prohibit anything less than the traditional funeral through their licensing requirements."[62]

Representatives of the National Retired Teachers Association and the American Association of Retired Persons (NRTA/AARP) testified in favor of the proposed rules. NRTA/AARP explained:

> Exorbitant and unnecessary funeral costs have drastic economic effects on many elderly survivors who are forced to live on low and fixed incomes. Our association believes elderly consumers could save a significant amount of money when purchasing funeral services if adequate price information were available. That's why we have strongly supported the FTC's proposed rules.[63]

A funeral director testifying at an FTC hearing in Georgia stated that he was taught in mortuary school "how to take advantage" of

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[58] See *Developments in Aging: 1975 and January–May 1976*, part 1, Senate Rept. No. 94–998, Special Committee on Aging, U.S. Senate, p. 188, for a summary of the proposed trade regulation rule and a discussion of supporting and opposing views. See Federal Register, vol. 40, Aug. 29, 1975, p. 39901, for the full text of the proposed trade regulation rule.

[59] Hearings were held in New York City the week of April 20, 1976; in Chicago, May 10, 1976; in Atlanta June 28, 1976; in Seattle July 1, 1976; and in Washington, D.C. from July 19, 1976 through Aug. 6, 1976.

[60] Comments of Virginia H. Knauer on behalf of the Office of Consumer Affairs, before the Federal Trade Commission, In the matter of a proposed trade regulation rule on funeral industry practices, Office of Consumer Affairs, p. 2.

[61] Testimony cited in footnote 60, p. 3.

[62] Testimony cited in footnote 60, p. 8.

[63] "New Hope for Sensible Funerals," NRTA Journal, November–December 1976, p. 63.

families consulting him about a funeral and how to display expensive caskets more attractively than cheaper models to grieving members of bereaved families.[64]

Other members of the funeral industry have registered strong opposition to the proposed rule. In April 1976, the National Funeral Directors Association filed a suit, subsequently turned down by the courts, asking for a temporary restraining order to enjoin the FTC from taking further action on the proposed rule. Industry opposition was also evident during hearings conducted by the Subcommittee on Activities of Regulatory Agencies of the House Small Business Committee in March, 1976.[65] During 6 days of hearings, several members of the industry appeared before the subcommittee to argue against the proposed rules.

The subcommittee took issue with certain aspects of the proposed rule which it found to be most harmful to small businesses,[66] although it stated that it "recognized merit in some of the concepts behind the proposed regulation; namely, that of complete price disclosure and the education of consumers to make more knowledgeable consumer decisions."[67]

The subcommittee report concluded:

> Considering the local nature of the business, the incidental effect on interstate commerce, and the lack of demonstrable abuse, the subcommittee finds no compelling need for Federal regulation of the funeral industry, and concludes that the interests of the public and small business will be better served if the funeral industry is regulated by the States.[68]

The subcommittee hearings followed introduction of legislation in both the Senate and the House in late 1975 to challenge the FTC's authority to override State law based on issuance of the proposed funeral industry regulations.[69]

Much of the testimony before the FTC on the proposed rules, however, as well as the FTC staff investigation of the industry, questioned whether existing State laws are adequate to protect consumers against abuse.

In testimony before the FTC, Representative Henry A. Waxman of California said the proposed rules could improve legislation previously adopted in California to regulate the funeral industry.[70]

> [The FTC] has already received extensive testimony at its hearings in Los Angeles which indicated that the protec-

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[64] Article in Atlanta Journal, June 28, 1976.

[65] "Federal Trade Commission's Proposed Funeral Industry Trade Regulation Rule: Its Effect on Small Business," a report of the Subcommittee on Activities of Regulatory Agencies of the Committee on Small Business, House of Representatives, House Rept. No. 94-1761, Oct. 20, 1976.

[66] Report cited in footnote 65, pp. 23-24. The subcommittee found proposals to require a funeral director to supply a customer with a form stating what is not required by law for a funeral; to furnish a customer, on request, a written explanation of a legal requirement, including public health regulations, which necessitate the use of any services or merchandise; and to furnish the customer with a form which suggests the customer "may want" to visit a competitor of the funeral director to compare prices "abhorrent to free enterprise and a requirement not imposed upon any other line of business."

[67] Report cited in footnote 65, p. 29.

[68] Report cited in footnote 65, p. 29.

[69] H. Con. Res. 505, introduced by Representative Ashbrook on Dec. 10, 1975; H. Con. Res. 483, introduced by Representative Stuckey on Nov. 18, 1975; and S. Con. Res. 77, introduced by Senator Curtis on Nov. 18, 1975, declare that Congress has not delegated to the FTC any authority to preempt the laws of the States or their political subdivisions.

[70] California 1971 Funeral Practices Statute.

tions afforded by these rules are necessary to redress the deficiencies in the California statute . . . [Although previous testimony] outlined more than a dozen areas in which the California law does not measure up to the proposed rules—to the detriment of consumers in California—there are two major concerns I have about this.

First, section 7685 of the California Business and Profession Code does not require that all casket prices be listed, but only that the range of prices—from the cheapest to the most expensive—be provided to a customer. Such a range, though helpful, does not at all permit an informed evaluation of the available alternatives. The proposed regulations do.

Second, the State law does not require the furnishing of a price list of all goods and services on request, as provided by section 453.5(e) of the FTC's proposed regulations. Although extensive itemization is required in California at the signing of the memorandum of agreement, the unavailability of this information at the outset robs the consumer of the ability to shop comparatively. I submit it is very difficult for the consumer to extricate himself from finalizing the contract in the minutes before it is to be signed—especially given the need to move quickly to arrange for the funeral. So even if the price is too high, the consumer may well be inhibited from getting out. The proposed regulations effectively deal with this situation.[71]

Representative Waxman concluded:

> I believe that preemption of State law in this area is not only consistent with the Federal regulation of interstate commerce, generally, but necessary if the regulations are to meet the needs to which they are addressed. Time after time, the staff has documented that adequate laws on the State level either do not exist or are not enforced. In many States, including California, this is so because the State boards which license funeral directors and receive consumer complaints are often composed primarily or exclusively of industry representatives.[72]

Mr. Julian B. Rosenthal, a member of the Georgia Joint State Legislative Committee of NRTA-AARP, testified on behalf of association members in Georgia, Florida, Alabama, Tennessee, and South Carolina and described existing State regulation of the funeral industry in Georgia and Florida. Mr. Rosenthal concluded that "in neither of these two States, in one of which the consumer is almost entirely ignored, and in the other where there has at least been a study made of the problem, is the public protected against the abuses, fraud, and deception which the FTC seeks to eliminate by the adoption of this proposed rule."[73]

Mr. Rosenthal went on:

> We arrive at the staggering total for annual expenditures for funerals and related items of approximately $4.2 billion,

[71] Congressional Record, Aug. 5, 1976, p. E 4391.
[72] Testimony cited in footnote 71.
[73] In testimony before the Federal Trade Commission in Atlanta, Ga., June 28, 1976.

of which nearly $500 million is paid by the Federal Government in fulfillment of its responsibility to veterans, social security recipients, and others who are entitled to this Government benefit.

Beyond question, if consumers are furnished with price information as would be required by section 453.5 of the FTC proposed rule, there will be a significant reduction in the cost of funerals. For one thing, it will give the prospective purchaser an opportunity to compare prices quoted by more than one funeral director, and for another, it will make it possible for the consumer to make a more intelligent selection of the merchandise which he will require for his particular purpose, very often before the event.[74]

The FTC expects to issue final rules for the funeral industry in March 1977. Many observers expect that the rules will be appealed during the 60-day comment period between issuance of the final rules and their implementation.

VIII. IMPLEMENTING THE CREDIT LAW

The Equal Credit Opportunity Act Amendments of 1976 (Public Law 94-239, enacted into law on March 23, 1976) contained provisions—effective March 23, 1977—to prohibit discrimination against credit applicants on the basis of age or source of income.[75]

Since enactment of the amendments, several actions have been taken by the Federal Reserve Board to implement the law and insure that the current patterns of credit discrimination against older Americans are eliminated.[76]

On July 20, 1976, the Federal Reserve Board published for comment proposed rulemaking to implement the law.[77] Hearings on these proposed rules were held during August 1976, and a revised set of proposed rules were published in November 1976.[78] Final action on regulations is expected in early 1977, prior to the effective date of the law in March.

As currently proposed, the regulations:

—Prohibit discrimination against credit applicants because of race, color, religion, national origin, sex, marital status, or age. The regulations expressly prohibit a creditor [79] from taking into account an applicant's age except for the purpose of determining the amount and probable continuance of income levels. Age can be used as a factor in a credit scoring system if the system is empirically derived and demonstrably and statistically sound, and

[74] Testimony cited in footnote 73.

[75] See *Developments in Aging: 1975 and January-May 1976*, part 1, S. Rept. No. 94-998, Special Committee on Aging, U.S. Senate, p. 204, for a discussion of congressional action and testimony from representatives of national organizations on aging urging passage of this legislation.

[76] The Senate Committee on Banking, Housing, and Urban Affairs and the House Committee on Banking, Currency, and Housing paid special attention to reports of credit discrimination based solely on age during their consideration of the bill. Both committees found that discrimination did exist, even though senior citizens are often better than average credit risks. S. Rept. No. 94-589, report of the Committee on Banking, Housing, and Urban Affairs, U.S. Senate, Jan. 21, 1976. H. Rept. No. 94-210, report of the Committee on Banking, Currency, and Housing, U.S. House of Representatives, May 14, 1975.

[77] Federal Register, vol. 41, July 20, 1976, p. 29870.

[78] Federal Register, vol. 41, Nov. 8, 1976, p. 49123.

[79] Under the terms of the law, the act defines a creditor as all those who normally extend credit, including banks, credit card companies, finance companies, and department stores.

provided that the age of an elderly applicant is not assigned a negative value. In any system of evaluating creditworthiness, a creditor may consider the age of an elderly applicant when it is to be used to favor an elderly applicant in extending credit.

—Prohibit creditors from discounting or excluding from consideration as income any retirement income, part-time income, or any income from public assistance, including social security and supplemental security income.

—Require creditors to respond to credit applications within 30 days of receipt.

—Require creditors to furnish an applicant who has been denied credit with a statement of the reasons for denial.

—Provide for penalties up to $10,000 for cases of individual discrimination.

The Senate Committee on Aging welcomes the prompt actions by the Board of Governors of the Federal Reserve Board in developing regulations to implement the Equal Credit Opportunity Act Amendments of 1976 and its efforts in assuring all parties an opportunity to comment during the hearing process. The committee urges, however, that enforcement activities include an aggressive campaign to see that the provisions of the law are widely publicized and understood.[80]

IX. ARCHITECTURAL BARRIERS: STRICTER ENFORCEMENT, NEW REGULATIONS

The Architectural Barriers Act of 1968 recognized the problems faced by millions of Americans in utilizing public buildings.[81] However, it had become clear by 1975 that the law was simply not having a major impact on the elimination of barriers due to deficiencies in scope and enforcement.[82] Action taken late in the 94th Congress aimed at removing these shortcomings. Meanwhile, the Congress also provided stimulation for barrier elimination in the private sector through a new provision in the tax code.

In the executive branch, several actions made clear that a greater commitment would be directed toward enforcing both the letter and the spirit of the Barriers Act and the Rehabilitation Act of 1973.

A. Congress Strengthens the Barriers Act

A 1975 General Accounting Office critique of the Barriers Act found shortcomings in its enforcement and recommended additional congressional action to correct the situation.[83] The Public Buildings Cooperative Use Act, enacted in October 1976, addresses those deficiencies by incorporating most of the GAO's recommendations.[84]

[80] Equal Credit Opportunity Act, a pamphlet prepared by the Federal Trade Commission outlining the provisions of the law and how they effect individual consumers, is being updated to include the new provisions against age discrimination and will be available through FTC offices after March 1977.

[81] Estimates of America's physically handicapped population range from 13–22 million; the Administration on Aging says that about one-third of the elderly (roughly 7 million) have some type of physical disability.

[82] See *Developments in Aging: 1975 and January–May 1976*, part 1, pp. 198–9.

[83] "Further Action Needed to Make All Public Buildings Accessible to the Physically Handicapped," General Accounting Office report No. FPCD–75–166, July 15, 1975.

[84] Public Law 94–541, enacted Oct. 18, 1976.

Title II of the act imposes a clear statutory mandate that all included Federal agencies insure accessibility; extends the Barriers Act's coverage to all Government-leased buildings which are intended for public use or in which the handicapped might be employed, as well as to all private structures leased for public housing; and brings the Postal Service within the strictures of the Barriers Act. In addition, the General Services Administration is now required to issue an annual report on the status of Barriers Act developments; all affected Federal agencies are directed to establish a system of continuing surveys to insure compliance; and the Architectural and Transportation Barriers Compliance Board (A & TBCB) must report to the appropriate Senate and House committees during the first week of each January on the status of its activities and the actions it has taken to insure compliance with the prescribed standards.

B. A & TBCB: Membership and Activities

The Architectural and Transportation Barriers Compliance Board has representatives from nine Federal agencies and is charged with the enforcement of the standards of accessibility as specified by the Barriers Act and other relevant legislation and regulations. It also must "investigate and examine alternative approaches to the architectural, transportation, and attitudinal barriers confronting handicapped individuals." [85] HEW is its parent agency; the Assistant Secretary of Human Development is designated as chairperson.

A & TBCB took several actions in 1976 which could portend a strong and effective commitment to its assigned tasks:

—In May it announced 16 appointees to the new National Advisory Committee on an Accessible Environment. Most are disabled, and the remainder are professionals and volunteers working on behalf of the mobility restricted. The committee will report on its activities each September. Its job is to render advice, propose legislative and administrative measures, and promote cooperation among organizations representing the handicapped.

—In June A & TBCB issued its proposed hearing procedures. This will be the formal system for determining the validity of complaints against barriers which allegedly violate Federal standards.[86] After considering received comments, the procedures were made final in December.[87]

—And in July, the board issued a notice outlining the history and responsibility of both itself and other Federal units under the 1968 Barriers Act and 1973 Rehabilitation Act. The notice also lists the processes and components which A & TBCB deems necessary to insure effective and efficient compliance.[88] The board has engaged the services of a private contractor to assist in the development of these procedures.[89]

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[85] This language is found in the Rehabilitation Act of 1973, which created the A & TBCB.
[86] 36 CFR Part 1150, Federal Register, vol. 41, No. 113, June 10, 1976, pp. 23598–23603.
[87] Practice and Procedure for Compliance Hearing; Federal Register, vol. 41, No. 245, Dec. 20, 1976, pp. 55442–55451.
[88] Guidance for Compliance System Development; Federal Register, vol. 41, No. 128, July 1, 1976, pp. 27192–27196.
[89] Conversation with Charles Goldman, General Counsel, A & TBCB, Nov. 12, 1976.

C. New Tax Provisions Concerning Barriers

A provision of the Tax Reform Law of 1976 [90] is designed to encourage the elimination of barriers existing within the private sector. Section 2122 modifies the usual method of capitalization and depreciation by providing an elective current deduction for the removal of architectural and transportation barriers in any facility or public transit vehicle owned or leased for use in a trade or business. The maximum deduction is $25,000 per taxpayer in any taxable year from 1977 to 1979. To be eligible, the removals must meet Government standards.

D. Office for Civil Rights Responsibilities

The Office of Civil Rights is a unit of the Department of Health, Education, and Welfare (HEW). It has been moving toward the issuance, in final form, of regulations implementing section 504 of the Rehabilitation Act of 1973. That section reads:

> No otherwise qualified individual in the United States . . . shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Two notices of proposed regulations elicited hundreds of comments from across the Nation requiring review by office staff.[91] It is expected that Secretary Califano will decide whether the regulations should be approved and issued by the end of February 1977.[92]

These regulations are designed to insure that HEW's own programs and activities are free from discrimination on the basis of handicap. However, HEW has not yet begun to address its other responsibility of coordinating Government-wide enforcement of section 504 and issuing general standards for other departments and agencies.

In their initial form, the regulations stated that:

> Handicapped persons may require different treatment in order to be afforded access to federally assisted programs and activities, and identical treatment may, in fact, constitute discrimination.

Comments received in regard to this language have resulted in this view being deemphasized; HEW's official view now is that the intent of section 504 is to guarantee that the handicapped receive the same services as the nonhandicapped. Separate services will be offered only when that course is essential to the delivery of services of equal quality.

HEW's proposed section 504 regulations adopt the American National Standards Institute's (ANSI) accessibility standards as the minimum requirements for new design and construction. HEW is aware that many persons feel that these standards are insufficient and outdated. However, the Department of Housing and Urban Develop-

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[90] Public Law 94-455, enacted Oct. 4, 1976.

[91] 45 CFR Part 84; Federal Register, vol. 41, No. 96, May 17, 1976, pp. 20296-20311; vol. 41, No. 138, July 16, 1976, pp. 29548-29567.

[92] Conversation with William van den Toorn, Executive Assistant to the Director, Office for Civil Rights, Feb. 14, 1977.

ment (HUD) is sponsoring a research project at Syracuse University to update and improve the ANSI standards and to add new sections dealing with housing design.[93]

Under the Rehabilitation Act, HEW and A & TBCB have concurrent jurisdiction for the enforcement of barriers laws. Procedures to facilitate and formalize this joint responsibility are still being worked out; in the interim, HEW defers to A & TBCB for a 60-day period when an enforcement conflict is apparent.

E. New Developments in Transportation Barriers

The cooperative relationship which has developed between A & TBCB and HEW has not, unfortunately, extended to the dealings between the barriers board and the Department of Transportation (DOT) and, in particular, DOT's Urban Mass Transit Administration (UMTA). In the past, they have been in conflict over accessibility standards for the Washington Metro subway system and the interpretation of section 16 of the Urban Mass Transportation Act of 1970. That section declares it to be national policy that the elderly and handicapped have equal rights in utilizing federally assisted mass transit facilities and services.

Section 16 of the UMT act alone would seem to require more accessible transit vehicles. In addition, both A & TBCB and the General Services Administration are of the opinion that section 504 of the Rehabilitation Act applies to all transit vehicles purchased with Federal dollars. But UMTA's recently issued bus regulations would seem to indicate a contrary view.[94]

F. A Barrier-Free Future?

The developments listed above could go far toward implementing the national goal of a barrier-free environment first expressed in the 1968 Barriers Act. However, the following actions are needed to expedite matters:

—A & TBCB should make final its compliance procedures, as it has already done with its hearing procedures. This is necessary if it is to successfully handle the increased responsibilities delegated to it by the Public Buildings Cooperative Use Act.

—HEW should finish its review of comments on its section 504 regulations, issue them in final form, and move on to its duties of coordinating enforcement and setting standards for other departments.

—The controversy surrounding accessibility standards for mass transit vehicles must be resolved.

—Congress should continue to exercise vigilant oversight to assure that title II of the Public Buildings Cooperative Use Act results in effective implementation of the Barriers Act. In addition, Congress should monitor the private sector's response to section 2122 of the Tax Reform Act and, if that reaction is favorable, consider extending it beyond 1979.

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[93] Conversation with Margaret Milner, director of program, Center for a Barrier-Free Environment, Washington, D.C., Nov. 12, 1976.

[94] Source cited in footnote 89, conversation of Nov. 22, 1976. For a fuller discussion of UMTA activities and transportation barriers, see chapter VII of this report.

X. THE TAX REFORM ACT AND THE ELDERLY

Shortly before adjournment, Congress passed a massive tax bill—the Tax Reform Act of 1976[95]—which made far-reaching changes in the Internal Revenue Code.

The Joint Committee on Internal Revenue Taxation estimates that the new 412-page law will raise an additional $1.6 billion in fiscal 1977 by closing certain loopholes. At the same time, it will provide $17.3 billion in tax relief in fiscal 1977, primarily through the extension of previously enacted tax reductions.[96] The act also rewrites much of the Federal estate and gift tax provisions.

Over 2 years of deliberations went into the final product. Of special significance to older Americans, the act permits aged individuals to have $5,818 in taxable income in 1976 and not be subject to Federal income tax. An elderly couple may have $9,234 in taxable income under the new law and be exempt from Federal income tax.[97]

A. Major Changes Affecting the Elderly

Public Law 94–455 makes numerous changes in the Internal Revenue Code, including several with a direct impact upon the elderly. Among the major provisions affecting older Americans:

General tax credit: A credit equal to the greater of $35 per personal exemption or 2 percent of the first $9,000 of taxable income is effective in 1976. No additional credit is available for age or blindness.

Standard deduction: The 1975 increases in the standard deduction (from 15 percent to 16 percent of adjusted gross income with a boost in the overall ceiling from $2,000 to $2,400 for single persons and $2,800 for couples filing jointly) and the minimum standard deductions (from $1,300 to $1,700 for individuals and $2,100 for couples) become permanent in 1976.

Excludable gain from the sale of a personal residence: Under existing law, an individual may elect to exclude from gross income part or, under certain circumstances, all of the gain from the sale of a personal residence, provided:

(1) The taxpayer is 65 or older before the date of sale, and

(2) The taxpayer owned and occupied the property as a personal residence for at least 5 years within an 8-year period ending on the date of sale. Taxpayers meeting these two requirements may elect to exclude the entire gain from gross income if the adjusted sales price[98] of the residence is $20,000 or less. This election, though, can only be

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[95] Public Law 94–455, approved Oct. 4, 1976.

[96] "Summary of the Tax Reform Act of 1976 (H.R. 10612, 94th Cong., P.L. 94–455)," prepared by the staff of the Joint Committee on Internal Revenue Taxation (the name changes on Feb. 1, 1977, to the Joint Committee on Taxation).

[97] Tax-free income levels—Tax Reform Act of 1976: (a) Single person aged 65 or older—$5,818: The $1,700 minimum standard deduction plus the two personal exemptions totaling $1,500 (one regular exemption of $750 and an additional exemption of $750 because of age) equal $3,200. Of the remaining $2,618 taxable income, the tax of $370 is offset by the 2-percent general tax credit and the 15-percent elderly credit (on up to $2,500 in qualifying income for individuals). (b) Married couple, both spouses aged 65 or older—$9,234: The $2,100 minimum standard deduction plus the 4 personal exemptions totaling $3,000 (two regular exemptions of $750 each and 2 additional exemptions of $750 each because of age) equal $5,100. Of the remaining $4,134 taxable income, the tax of $434 is offset by the 2-percent general tax credit and the 15-percent elderly credit (on up to $3,750 in qualifying income for aged couples). Source: Joint Committee on Internal Revenue Taxation.

[98] The adjusted sales price of a personal residence is the sales price minus selling expenses and any qualifying fix-up expenses to make the house more salable.

made once during a taxpayer's lifetime. If the adjusted sales price exceeds $20,000, part of the gain may be excluded—based on a ratio of $20,000 over the adjusted sales price of the residence.

Public Law 94–455 allows elderly taxpayers to exclude the entire gain from the sale of a personal residence, provided the adjusted sales price is $35,000 or less (beginning in 1977). A pro rata amount is excludable if the adjusted sales price exceeds this amount. This change will provide elderly taxpayers with an estimated $4 million in tax relief in fiscal 1977 and $25 million in fiscal 1978.

Revision of the Retirement Income Credit: The Tax Reform Act replaces the retirement income credit with an elderly credit for taxpayers aged 65 or older. The new credit applies to earned income, as well as retirement income (pensions, annuities, interest, dividends, and rent). In addition, it raises the maximum amounts to compute the 15-percent credit from $1,524 to $2,500 for single aged persons and from $2,286 to $3,750 for elderly couples (both spouses are 65 or older) filing joint returns. As under existing law, these maximum amounts are reduced by certain types of tax-exempt income, such as social security benefits. Moreover, the new law reduces the maximum amounts by $1 for each $2 of adjusted gross income (line 15c on the 1976 Form 1040) above $7,500 for a single aged person and $10,000 for a married elderly couple filing a joint return. Thus, the credit is phased out entirely for a single person with adjusted gross income of $12,500 and an elderly couple with $17,500 (assuming in both cases, they have no tax-exempt Federal benefits). Aged and aging Americans are expected to receive $391 million in tax relief in fiscal 1977 under the new elderly credit.

Individual Retirement Account for Spouse: The Employee Retirement Income Security Act [99] allows persons who are not covered by qualified pension plans to deduct up to $1,500 or 15 percent of compensation from gross income (whichever is less) for purposes of establishing an individual retirement account. The IRA deduction is not allowed to a person contributing to the retirement account of another. Public Law 94–455 permits a qualifying individual (beginning in 1977) to contribute up to $875 to his own IRA and $875 to an IRA separately owned by a spouse (or contribute up to $1,750 to an IRA account which credits $875 to a subaccount for the husband and $875 to a subaccount for the wife). The deduction is still limited to 15 percent of compensation. The Joint Committee on Internal Revenue Taxation estimates that this change will provide an additional $2 million in individual income tax relief in fiscal 1977 and $14 million in fiscal 1977 and $14 million in fiscal 1978.

Changes in Sick Pay Exclusion: The existing sick pay exclusion is generally repealed and replaced with a maximum annual exclusion up to $5,200 for individuals under 65 who have retired on disability and are permanently and totally disabled (unable to engage in any substantial gainful activity because of a physical or mental impairment which is expected to last for at least 12 months or result in death). After age 65, these retirees will be eligible for the revised elderly credit. The maximum amount excludable must be reduced on a dollar-for-dollar basis by an individual's adjusted gross income (including disability income) in excess of $15,000 (this amount applies to individual and joint returns).

[99] Public Law 93–406, approved Sept. 2, 1976.

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Credit for Dependent Care Expenses: The existing itemized deduction for dependent care expenses is replaced with a tax credit equal to 20 percent of employment-related expenses (up to $2,000 for one dependent and $4,000 for two or more dependents) for the care of a child under 15 or an incapacitated dependent or spouse in order to enable the taxpayer to work. Thus, the maximum credit in 1976 is $400 for one dependent and $800 for two or more dependents. This change will reduce individual income taxes by $384 million in fiscal 1977.

Tax Simplification Study: The Joint Committee on Internal Revenue Taxation is directed to undertake a study to simplify the income tax law. A report is to be submitted to the Senate Finance and House Ways and Means Committees by June 30, 1977.

Unified Estate and Gift Tax Credit: The act provides a unified estate and gift tax credit equivalent to an exemption of $120,667, effective in 1977. The existing estate tax exemption is $60,000, and the present lifetime gift tax exemption for a donor is $30,000. After 1980 the unified credit will be the equivalent of an exemption of $175,625.

Increase in Estate Tax Marital Deduction: Public Law 94–455 increases the estate tax marital deduction for small- and moderate-sized estates passing to a surviving spouse. The allowable deduction (beginning in 1977) for property passing to a spouse is the greater of $250,000 or one-half of the decedent's adjusted gross estate.

B. An Older Americans Tax Counseling Assistance Act

Many older Americans needlessly overpay their taxes each year, for several reasons. Large numbers are simply unaware of helpful deductions which can save them precious dollars. Others are bewildered by the complexities in the tax form or the tax law.

Quite frequently, the complexities in computing a tax return become intensified with advancing age. Older taxpayers are frequently confronted with an entirely new set of tax rules upon reaching retirement age, usually far more complicated than during the preretirement years.

In January 1975, Senator Church introduced legislation—the Older American Tax Counseling Assistance Act, S. 390—to provide tax preparation assistance for the elderly.

This measure would authorize the Internal Revenue Service to enter into training and technical assistance agreements with nonprofit agencies to prepare volunteers to counsel elderly taxpayers. S. 390 would permit the tax counselors to be reimbursed for their out-of-pocket expenses in providing this service. In addition, the bill would authorize the Internal Revenue Service to conduct special alerts concerning tax relief measures of direct interest to older Americans, such as the elderly credit.

A major purpose of the legislation is to build upon the tax counseling assistance now made available through the tax aid for the elderly program, administered by the National Retired Teachers Association-American Association of Retired Persons.

The Older Americans Tax Counseling Assistance Act received strong bipartisan support in the Senate during the 94th Congress. All in all,

31 Senators [100] sponsored the bill. The Senate incorporated the provisions in S. 390 as an amendment to the Tax Reform Act. However, this measure was later deleted in conference committee.

FINDINGS AND RECOMMENDATIONS

Most older Americans do not pay any Federal income tax because their income is too low. But a surprisingly large number—more than 9 million—have a sufficient amount of income to file a Federal tax return.

For many of these individuals, the 1976 Tax Reform Act provides welcome tax relief. However, a need still exists to ease the tax burden of older Americans.

The committee recommends that the maximum amounts for computing the 15-percent elderly credit be raised to provide similar relief as now received by social security beneficiaries.[101] The committee recognizes that it may be necessary to achieve this goal on a step-by-step basis because of cost considerations.

Further, the committee urges that the tax form be simplified for elderly and younger taxpayers. The next Congress should also give prompt attention to the recommendations from the Joint Committee on Internal Revenue Taxation to simplify the tax law.

In addition, the committee recommends that an older Americans Tax Counseling Assistance Act be enacted promptly to build upon the effective work of the current tax-aide for the elderly program.

XI. EDUCATION FOR OLDER PERSONS

Participation in educational programs continued to flourish among the elderly during 1976.

Older persons often served during the bicentennial year as resource persons in history and American ways of life of the past.

They have been assimilated into school systems in many communities as tutors for slow learners and children with learning difficulties.

They have served in other school systems as qualified instructors in many fields.

Elderly professors have been sought to become consultants and advisors to faculty and students within their disciplines.

But older persons also have sought educational experiences for themselves, either at their own expense or with the help of public and private programs.

For example: Title III (grants to State and community programs on aging) of the Older Americans Act has funded section 308 model projects in several educational institutions and organizations to allow greater emphasis on programs for the older student.

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[100] Sponsors of the Older Americans Tax Counseling Assistance Act (S. 390, 94th Cong.) include Senators Church, Clark, Humphrey, Kennedy, Huddleston, Biden, Ribicoff, Williams, Bentsen, Burdick, Tunney, Chiles, McGee, Cannon, Thurmond, Bayh, Javits, McIntyre, Case, McGovern, Hartke, Hollings, Randolph, Gravel, Mondale, Jackson Hathaway, Beall, Fong, Haskell, and Stafford.

[101] The maximum social security yearly benefit for a worker retiring in 1976 at age 65 is $4,648 (and $6,972 for an elderly couple similarly situated when both spouses become 65 in 1976).

Universities, colleges, junior colleges, community colleges and high schools have opened their doors to the "nontraditional" students and have made special efforts to attract the elderly within their communities.

The elderly have helped to decide what courses they would like presented for the community's older citizens and have helped educational institutions in developing these courses. Some have asked for special instructions in health insurance, tax and social insurance programs. Others have merely wanted to enroll as a regular student and take courses ranging from Russian literature to yoga.

Whatever their choice, the elderly are making their universities and colleges aware of their presence and needs. And the enrollment of university campuses is beginning to represent the total population in terms of age groups.

A. Community Education

The Community Education Act (part of the Elementary and Secondary Education Act of 1974, Public Law 93-380) provided for $3.5 million in community education programs for fiscal year 1976 to support programs in 94 school districts, universities and State education agencies. The major objective is to make more effective use of existing educational resources through an extension of facilities and equipment to provide educational, cultural, recreational and other related services to the entire community.

The elderly community has been widely served by community education programs. In recognition of this effort, the Administration on Aging initiated a statement of understanding with the Office of Education to work cooperatively in advancing community education and its benefits for the elderly. The AoA/OE agreement agreed on the following objectives:

—To encourage the utilization of public school facilities, in meeting the nutritional needs of older persons;

—To create through public school resources greater opportunities for older people to participate in educational, recreational, cultural, and other related community services and to utilize their talents in the educational system;

—To help the youth understand the process of aging, and the life cycle; and

—To utilize where in existence and to promote the extension of public school facilities in providing a variety of programs, service opportunities, and other supportive services to the aged.

In addition, the Office of Education and the Administration on Aging sponsored a joint National Workshop on Community Education and Aging in October 1976. The conference brought together Governors' representatives, national and State leaders on aging, and community education personnel to exchange ideas and explore alternatives for opening up public schools as centers of service, learning, recreation, and volunteer opportunities for the elderly. The conference also provided leadership training in methods of developing such conferences or workshops at the State and local levels.

AoA has given State and area agencies on aging encouragement and procedural leadership on ways to coordinate such education programs

with the elderly community. The elderly have responded enthusiastically and are eager to participate in programs being sponsored by their local public schools.

Community education stresses the role of education to serve the entire community. Other educational programs and institutions have begun to open their eyes to the role of the educational field. It is a growing awareness that the scope of education has been narrow and geared toward the needs of the "traditional student." But, the system and the educators are analyzing their views and are beginning to move toward an educational program for everyone.

B. Lifetime Learning Act

Reflecting this trend, Senator Walter Mondale's "Lifetime Learning Act" was adopted and incorporated into the Higher Education Act of 1976.[102]

Under this law, an Office of Lifetime Learning within the Office of Education is responsible for coordinating existing efforts in the area of lifetime learning by all Federal agencies. In addition, the Lifetime Learning Act provides support for the training of teachers to work with adults, curriculum development, conversion of facilities to accommodate adults, and the development of media for adult education.

This new act also authorizes a study of the barriers to lifetime learning and the existing programs by the Office on Lifetime Learning.

A positive first step in the direction of education programs for all ages, the Lifetime Learning Act nevertheless does not provide funding for new programs in higher education. The authorized study and training will be useful in alerting educators and the public to specific needs and characteristics of the elderly population as learners and teachers. In Senate testimony John B. Martin, legislative consultant for the American Association of Retired Persons—National Retired Teachers Association and former U.S. Commissioner on Aging, stated:

> Lifetime learning is a "two-way" street, benefiting both the learner and the teacher. Older persons represent an invaluable resource in our society and offer many years of life and employment experience. They not only can be the recipients of a Lifetime Learning Act, but their wealth of experience also can be utilized in helping others to learn. Older persons should be considered a resource as we look to extended lifelong learning opportunities.[103]

XII. ERISA: PROGRESS ON PENSIONS

Labor Day of 1976 marked the second anniversary of the enactment of the Employee Retirement Income Security Act. This landmark legislation sought to deal with the findings, revealed by Senator Harrison Williams' pension plan study in 1971, that only 1 in 20 of those

[102] Public Law 94-482, signed into law on Oct. 12, 1976.
[103] Testimony by John B. Martin, legislative consultant to the NRTA/AARP before the Subcommittee on Education of the U.S. Senate Labor and Public Welfare Committee, Dec. 18, 1975.

workers who were employed and covered under pension plans and who had left that employment over the preceding 20 years, would ever receive any plan benefits. Workers in their forties and fifties were losing their pension rights due to plant shutdowns, transfers, store closings, and fund terminations.

ERISA affords to plan participants and their beneficiaries unprecedented, uniform Federal protection through requirements directed to participation, vesting, funding, reporting, and disclosure, and by the imposition of strict fiduciary standards on plan administrators. The impact of this law extends far beyond the retirement incomes of workers—it affects collective bargaining, large and small employers, banks, trust and insurance companies, lawyers, actuaries and consultants, and the flow of dollars into the stock, bond, and capital markets from the vast assets of private pension plans.

There is general agreement from all quarters that ERISA has created a new awareness among pension and welfare plan fiduciaries of their responsibilities to plan participants and their beneficiaries, and that the rights of participants have been greatly strengthened. But Senator Williams, coauthor of the bill with Senator Jacob Javits, is concerned over delays in implementing ERISA's legislative intent through effective and nonburdensome regulations. He has further charged that there has been "an unacceptable delay" [104] in enforcing the standards of trustee responsibility through vigorous investigative efforts.

A. ERISA's Regulatory Framework: The Record

The Department of Labor is responsible for reporting, disclosure, and fiduciary standards. It shares jurisdiction with the Internal Revenue Service for minimum standards of participation, vesting, benefit accrual, funding, and prohibited transactions and exemptions. Regulations have been issued in regard to reporting and disclosure, but gaps still remain in minimum participation standards and the funding provisions.

The Internal Revenue Service (IRS) has established a new Office of Employee Plans and Exempt Organizations to administer the Treasury Department's ERISA duties, including regulations covering annual registration, notification of interested parties concerning applications for determinations, participation, vesting, funding, and party in interest transactions, and the review of the qualified status of employee benefit plans. As of late 1976, most of IRS's regulations were not yet in final form.

The Pension Benefit Guaranty Corporation (PGBC) is a nonbudgeted, self-financing agency established to administer the plan termination program. PGBC is authorized to collect premiums from covered pension plans, to issue forms and regulations detailing termination procedures, and to develop a liability program capable of paying benefits to the participants of terminated plans. Two years after ERISA's enactment the regulations package necessary for processing terminations was taking shape but is still not fully in place.

[104] BNA Pension Reporter, Special Supplement No. 102, Sept. 6, 1976, p. 8.

ERISA's effective implementation has been delayed not only by this regulatory lag but by the failure of the Department of Labor and the IRS to respond adequately to their administrative responsibilities under ERISA, particularly in dealing with "prohibited transactions." Those provisions limit, in very broad terms, what fiduciaries may do with plan assets. Realizing that the breadth of the "prohibited transaction" provisions cast the legality of many long-recognized and non-abusive practices into doubt, Congress designed an administrative procedure whereby applicants could seek exemptions from the two agencies to engage in such practices when tax-qualified pension plans are involved. As of August 20, 461 requests for exemption had been filed, 420 of which required joint action. Six of the requests were granted; 33 were withdrawn; and almost all the rest were pending. Of the six requests granted, only three were decided jointly. This situation has prompted some officials within both Labor and IRS to assert that the primary responsibility for "prohibited transactions" should be placed within their agency.[105] Senators Williams and Javits have said they are taking a "wait and see" stance toward the spotty record of regulatory implementation on the part of both Labor and IRS.[106]

B. Reporting and Disclosure: Burdensome Requirements?

Criticism of the reporting and disclosure requirements on small businesses continues to be voiced. Senator Gaylord Nelson has charged, while conceding that "maladministration . . . is one of the chief underlying causes of the problem," that ERISA was having untoward effects on the 96.5 percent of pension plans with fewer than 100 participation.[107]

William J. Chadwick, administrator of pension and welfare programs at the Department of Labor, characterized Senator Nelson's remarks as "overdrawn." His letter of response asserted that his agency had taken a number of steps to lighten the paperwork burdens of ERISA: plans with fewer than 100 participants have been exempted from obtaining independent audits; welfare plans with fewer than 25 participants were exempted from submitting plan descriptions; the description form was shortened and improved; and the separate IRS and Labor reporting forms were combined into a single document. He said further that the Federal Paperwork Commission, initially critical of ERISA requirements, has praised the Labor Department's corrective efforts. Mr. Chadwick also wrote that exempting small plans from filing descriptions would raise serious questions of equity for their participants.

Chadwick cited a study finding that the majority of plan terminations have been for plans which will be superseded by new plans. The Labor Department takes the position that the present lower level of qualification requests is temporary and that there will be an upswing in applications when the start of 1977 permits the utilization of recent regulatory developments. It should be remembered that small

[105] National Issues Outlook (published as a supplement to National Journal), October 1976, p. 10.
[106] National Journal, vol. 8, No. 36, Sept. 4, 1976, pp. 1250–51.
[107] *Congressional Record*, vol. 122, No. 150, Sept. 30, 1976, pp. S 17393–7.

plans may comprise 96.5 percent of all plans, but they only cover 11 percent of participants. In fact, 90 percent of participants in private pension and welfare plans belong to less than 4 percent of total plans. Nonetheless, the Labor Department has contracted with Price Waterhouse accountants to study the cost impact of ERISA on small businesses.[108]

Senator Williams has said he believes that the new regulations promulgated by the Department of Labor in response to small employer problems "strike a proper balance between the participants' right to know about plan provisions and the plan's ability to operate without suffocating paper work requirements."[109] He is seeking to assure that the Labor Department is prepared to render aid and assistance to persons seeking advice in the preparation and filing of required documents. Both he and Senator Javits have endorsed simplifications which are consistent with ERISA's intent as to the amount and quality of information available to participants and beneficiaries and which can be effected administratively.[110]

C. An Appraisal and a Look Forward

Even ERISA's strongest advocates concede that its record to date has been a mixed one, and efforts to improve it are underway:

—To deal with complaints about burdensome filing requirements of small business employers, the Department of Labor has undertaken a study to assess the true cost to their employers.

—On April 15, a bill to permit the tax-free "rollover"[111] of retirement plan distributions into IRA accounts was enacted. This measure, correcting an oversight in the original bill, is retroactive to July 1, 1974, and allows the rollover either upon plan termination or discontinuance of employer contributions connected with liquidations or sales of subsidiary businesses.

—Congressional action may also be required if the decision of a U.S. district court in California is confirmed on appeal. In *Connolly* v. *Pension Benefit Guarantee Corporation* the judge held that multiemployer plans were not covered by ERISA's termination insurance provisions. This would remove PBGC protection from 8.5 million of the 30 million workers participating in private pensions, and particularly from those employed in the construction industry.

—Two other areas are under consideration. The first is a portability provision similar to the one suggested by Senator Williams during debate on ERISA, but deferred by Congress pending further study. It would permit employees to accumulate pension credits from various jobs and combine them in a single plan. The other would be extension of PBGC protection from pension plans to uncovered health and welfare plans. The cost of these extensions

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[108] Correspondence of William J. Chadwick to Senator Gaylord Nelson, Nov. 16, 1976.
[109] Correspondence of Senator Harrison A. Williams, Jr., to Boardman, Suhr, Curry & Field, Madison, Wis., Sept. 17, 1976.
[110] Correspondence of Senator Williams and Senator Jacob K. Javits to Frank Horton, Chairman, Commission on Federal Paperwork, Sept. 23, 1976.
[111] Public Law 94-267 permits the tax-free transfer of terminated retirement plan moneys into an employee's individual retirement account.

of ERISA must, of course, be balanced against the potential gains for American workers.[112]

XIII. DISASTER ASSISTANCE FOR THE ELDERLY VICTIMS

During 1976, Administration on Aging (AoA) staff assisted elderly in 29 disasters in 23 States, including tornadoes in Arkansas and Louisiana; floods in Oklahoma, North Dakota, Texas, Vermont, and Idaho; and earthquake tremors and tidal waves in Guam and the Virgin Islands. In each case, AoA staff were in early contact with aging services personnel to determine the catastrophic effects on elderly residents of the disaster areas.

Once the degree of damage for the elderly victims was determined, the AoA staff worked with disaster assistance teams in providing necessary benefits for the aged. Often, the title VII (Older Americans Act) meal sites and elderly transportation programs became the core for contact and delivery of disaster assistance benefits for the elderly. These services were continued until the Red Cross and other disaster relief organizations set up emergency systems. The AoA is reimbursed by the Federal Disaster Assistance Administration (FDAA) for the cost of supplying such benefits as title VII meals to nonelderly persons.

A. Federal Assistance

Since 1973, the Administration on Aging has had a small core group of field representatives trained [113] to work directly with the Federal Disaster Assistance Administration (FDAA) of the Department of Housing and Urban Development. In time of disaster they seek immediate contact with State and area agencies on aging in the affected areas. On-site visits are made by the liaison personnel, who transmit information to the Commissioner of Aging.

The FDAA and HUD have contractual relationships with the Red Cross, Young Lawyers, National Institute of Mental Health, and others for services rendered to disaster victims. Services provided by these agencies and others during a national disaster include:

—Temporary housing;
—Unemployment assistance;
—Food stamps and food commodities;
—Relocation assistance;
—Legal services;
—Crisis counseling assistance;
—VA loans;

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[112] Additional sources for this section include the following: Pension World Washington Newsletter, October 1976, pp. 5–6; speech of Senator Jacob K. Javits, Congressional Record, Sept. 30, 1976, pp. S 17462–3; conversation with Ian Lanoff, professional staff member, Senate Subcommittee on Labor, Dec. 15, 1976; and Administration of the Employee Retirement Income Security Act through Dec. 31, 1975; report of the Secretary of Labor to the Congress, November 1976.

Many American workers do not have retirement plans available at their place of employment. On September 29, 1976 the Subcommittee on Oversight of the House Ways and Means Committee issued a guide to IRA accounts to assist such uncovered employees in preparing for a financially secure retirement. "Individual Retirement Accounts—What the Consumer Should Know," WMCP:94–150, U.S. Government Printing Office, Washington, D.C.

[113] Staff who assist during disaster periods are the field liaison staff of AoA who serve as liaisons between the field and the central AoA offices.

—HUD loans;
—Federal Housing Administration (FHA) loans; and
—Small Business Administration (SBA) loans.

AoA, in turn, has close contacts with the provider agencies and works with the agency personnel at the Federal, State, and local levels to assure that the needs of the elderly are met.

Since January 1, 1973, there have been 160 nationally declared disasters in the United States. According to the National Disaster Act of 1974 (Public Law 93–288) a major disaster is:

> . . . any hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other catastrophe in any part of the United States which, in the determination of the President, causes damage of sufficient severity and magnitude to warrant disaster assistance under this act, above and beyond emergency services by the Federal Government, to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused hereby.

When such catastrophes occur, the AoA liaison disaster staff seek prompt contact with the appropriate regional aging office. AoA regional personnel work with area agencies and title VII projects to assure that they are functioning in the disaster areas by getting elderly victims to emergency centers and by instructing the elderly about specific disaster relief benefits.

B. Relationship of Disaster Assistance to SSI

When an elderly person receives disaster assistance benefits, there is often confusion about whether such assistance should be included as income under certain other Federal assistance programs. For instance, when the Teton Dam collapsed in Idaho in June 1976, more than 1,000 SSI recipients resided in the affected areas. These SSI recipients were faced with a reduction or total loss in their benefits because of the disaster. For example, if they had been forced out of their homes because of flood damage and had to take up resident in the home of another, they would, under the SSI statute, be faced with a one-third reduction in their SSI benefit. Therefore, the victims of a national disaster such as the Teton Dam collapse would be subjected to a loss in benefits at a time when conditions were pressing.

To deal with this problem Senator Frank Church introduced two amendments to the SSI law which would protect SSI disaster recipients. One amendment allowed SSI recipients an 18-month grace period to either return to their own household or take up a new residence before being subjected to the one-third reduction for living in the household of another.[114]

Also, Senator Church introduced an amendment which would exclude as income, under SSI calculations, any assistance received under

[114] This amendment was enacted as part of Public Law 94–331 which was signed into law on June 30, 1976, and was amended by Public Law 94–455 to include a grace period of 18 months.

the Disaster Assistance Act of 1974 and "other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President." [115] The following assistance would be exempt from income: temporary housing, food services, legal services, relocation services, employment services, counseling services, and loans from the VA, HUD, and others.

[115] Included in Public Law 94-331, enacted on June 30, 1976.

CHAPTER XII

ACTIVITIES AT THE STATE LEVEL

During 1976, a number of State governments continued efforts to strengthen the "network" [1] on aging within the State, expand State initiatives in programing for the elderly, and provide strong legislative support for improvement of the quality of life for all elderly. At the same time, however, fiscal and budget constraints in many State governments deepened during 1976, bringing austerity measures in many social programs.

Even though new funding for services for the elderly has been slowed down in many States, it is evident from a survey of State offices on aging undertaken by the Committee on Aging in November 1976, that the impact of the Older Americans Act continues to provide a solid base for State support of federally initiated social service and nutrition programs for the elderly. Some States are also moving to integrate the needs of the elderly into the State planning and budgeting process in a more comprehensive manner than in the past.

This chapter represents an overview of activities reported to the Committee on Aging by 28 States during 1976, and is meant to serve as an update of the report made on the Committee on Aging's more comprehensive 1975 survey of State activities and initiatives.[2]

I. DEVELOPMENTS IN STATE AGENCIES ON AGING

During 1976, a number of States reported that changes in organizational position or increased responsibilities for State offices on aging have either been acted upon or are now being considered by State legislatures.

A. Changes in Status During 1976

During 1976, the Idaho State Legislature created an Idaho Office on Aging as a separate agency with direct responsibility to the Governor's office.[3]

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[1] See chapter V for additional discussion of the "network."

[2] In 1975, State agencies on aging in 39 States, the District of Columbia, and the Virgin Islands responded to a committee survey asking for developments within the State during 1974 and 1975 which might be taken as indicators of trends in the development of State agencies on aging, in the interest in and priority given to problems of older Americans by State legislatures, and in programing for older Americans at both the State and local levels. An analysis of the responses to this survey are contained in *Developments in Aging: 1975 and January–May 1976*, part 1, A report of the Special Committee on Aging, U.S. Senate, Senate Rept. No. 94–998.

This year, the committee asked for similar information from all State offices on aging on activities which had taken place during 1976. Twenty-eight States responded to the committee request for information on changes in organizational position, budget, and responsibilities of the State office on aging; activities of the State legislature during 1976 which had a direct effect on the State's elderly population; and examples of programs developed within the State which the office on aging considered particularly noteworthy or innovative.

[3] Report of activities from Idaho Office on Aging, John M. McCullen, director, Nov. 17, 1976. House bill No. 405, second regular session, 43d legislature.

The Hawaii Legislature took action to replace the State commission on aging and county committees on aging with State and county executive offices on aging. The State office on aging was also transferred directly to the Governor's office from its position within the department of budget and finance. The newly created county offices on aging have 15-member policy councils, appointed by local executives, and authority to review and approve county office actions on aging.[4]

In August 1976, the Arkansas Office on Aging and Adult Services was transferred from a component of the division of social services to a position directly responsible to the director of the department of social and rehabilitative services. This move is perceived within the State as a way to offer increased visibility and capability for coordination of services to the elderly.[5]

The Rhode Island Division on Aging expects a bill to be introduced in the next legislative session to give the division full departmental status,[6] and North Carolina reports that the Governor has called for upgrading the office for aging to a division of aging.[7]

B. Increased Responsibility

Offices in California, New York, and Massachusetts all report substantially increased roles and responsibility for the comprehensive coordination of services to the elderly within their States.

California.—In June 1976, Governor Brown signed executive order B–15–16 to establish the California Interdepartmental Committee on Aging. All State agencies sponsoring programs for the elderly will work together on this committee.[8]

New York.—Governor Carey assigned new coordination responsibilities to the New York Office on Aging through executive order 34, which gave the office on aging power to comment on all proposed actions of other agencies which would affect the State's elderly. This increased responsibility includes a role in commenting on the impact of proposed legislation and new regulations on existing aging programs and charges the office on aging with making recommendations and modifications to proposals to enhance their effect on New York's elderly.[9]

Massachusetts.—In Massachusetts, a transfer of responsibility for all social services for the elderly from the department of public welfare to the cabinet-level department of elder affairs is now underway. Included in this transfer will be social services to supplemental security income recipients under title XX of the Social Security Act. All homemaker and chore services provided to SSI recipients under Title

[4] Report of activities from Hawaii Commission on Aging, Renji Goto, director, Nov. 30, 1976. Act 217.

[5] Report of activities from Arkansas Office on Aging and Adult Services, Phil S. Peters, director, Dec. 9, 1976.

[6] Report of activities from Rhode Island Division on Aging, Eleanor F. Slater, (later retired) chief, Nov. 16, 1976.

[7] Report of activities from North Carolina Office for Aging, Robert Q. Beard, executive director, Nov. 30, 1976.

[8] Report of activities from California Department of Aging, Janet J. Levy, director, Nov. 19, 1976. Executive order B–15–16, signed June 7, 1976.

[9] Report of activities from New York State Office for the Aging, Jerry Billings, deputy director, Dec. 6, 1976. Executive order No. 34, signed May 4, 1976.

XX will be the responsibility of the department of elder affairs by June 1977, and will be provided through the department's current network of home care corporations throughout the State.[10]

In addition, Oklahoma and Alaska report State office on aging designation for implementation of the Urban Mass Transit section 16(b)(2) program which provides funding to States for specialized transportation services for the elderly and handicapped.[11]

C. State Offices on Aging Budgets

Of the 28 States responding to the Committee on Aging's 1976 survey, only five reported any significant increase in their budgets.

In California, the California office on aging received a special allotment of $123,216 to develop and complete a long-range plan for a statewide network of comprehensive services for the elderly. The network is to be completed by October 1977.[12]

In Washington, the State legislature appropriated $1.9 million for implementation of the Washington State Senior Citizens Services Act.[13]

D. Title XX Agreements

As experience grows in the implementation of each State's title XX social services plan,[14] more State offices on aging report increased involvement in decisions made within the State about use of these funds and increased formal involvement in statewide title XX planning mechanisms.

Of the 28 State offices on aging responding to this 1976 survey, 13 reported continued or improved involvement in the State's title XX planning process. A number of directors cited what they felt were significant gains in their participation in the planning process and reported completion of formal working agreements between State offices on aging and State agencies responsible for development and administration of the State title XX plan. Often, those who felt they had been particularly successful in implementing the plans and achieving coordination between titles III and VII of the Older Americans Act and title XX cited continuing and formal "followup" measures as largely responsible for their success.

State offices on aging in North Dakota and Virginia report participation in statewide title XX review and advisory committees.[15] California, Washington, West Virginia, Colorado, Massachusetts, Maryland, and New Hampshire have, according to their reports, strong

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[10] Report of activities from Massachusetts Department of Elder Affairs, S. Raymond King, assistant secretary, Dec. 9, 1976. Sec. 2, ch. 226 of the Acts and Resolves of 1976, Commonwealth of Massachusetts.

[11] Report of activities from Oklahoma Special Unit on Aging, Institutions, Social and Rehabilitative Services, L. E. Rader, director, Nov. 18, 1976. Report of activities from Alaska Office on Aging, Dan Plotnick, coordinator, Nov. 16, 1976.

[12] Report cited in footnote 8.

[13] Report of activities from Washington Office on Aging, Charles E. Reed, acting chief, Nov. 29, 1976. See p. 184 for a discussion of Washington's implementation of this legislation.

[14] See chapter V for additional discussion of title XX and titles III and VII of the Older Americans Act.

[15] Report of activities from North Dakota Aging Services, G. D. Shaw, administrator, Nov. 18, 1976. Report of activities from Commonwealth of Virginia Office on Aging, Joel Barr, assistant director, Nov. 17, 1976.

working agreements with agencies administering title XX social service funds.[16]

Washington.—In Washington, a working task force was set up to implement the agreement between the Washington Office on Aging and the Washington State Office of Family, Children, and Adult Services. This task force found several problems emerging in coordination of title XX social services and title III services administered by area agencies on aging throughout the State including lack of common definitions for services, lack of information on all services available to older people, and an unclear understanding of the planning process involved on both sides. The task force recommended written coordination agreements between area agencies on aging and all regional offices of the department of social and health services, the development of common service definitions and reporting systems, and the development of long-range plans for both departments.[17]

California.—The department of aging and the department of health have completed an agreement on titles III and VII of the Older Americans Act and title XX to promote the development of a comprehensive, coordinated service system for the elderly, statewide. In order to implement the agreement, formal liaisons between agencies have been appointed and joint planning meetings are held.[18]

Maryland.—In Maryland, the State Office on Aging has contracted with the Department of Human Resources to use title XX money to extend the hours of operation for title VII nutrition sites and provide care for the frail elderly. The Maryland Office on Aging and the Department of Health and Mental Hygiene and Department of Human Resources formed an interdepartmental grant review committee to assign use of title XX money for day-care services.[19]

South Carolina.—The South Carolina Commission on Aging reports administration of over $1 million in title XX contracts for day care, transportation, chore services, recreation, and home delivered meals for the elderly.[20]

In two States, West Virginia and Arkansas, the State office on aging provides State money to local area agencies on aging to be used for title XX match.[21]

II. REPORTS OF INNOVATIVE PROGRAMING

State offices on aging reported innovative programs for the elderly in a number of areas during 1976. Many States report activity in development of legal service programs, specialized health programs, and in community alternatives to institutional care.

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[16] California: Report cited in footnote 8. Washington: Report cited in footnote 13. West Virginia: Report of activities from West Virginia Commission on Aging, Louise B. Gerrard, Ph. D., executive director, Dec. 13, 1976. Colorado: Report of activities from Colorado Division of Services for the Aging, Department of Social Services, Dorothy D. Anders, director, Nov. 17, 1976. Massachusetts: Report cited in footnote 10. Maryland: Report of activities from State of Maryland Office on Aging, Matthew Tayback, Sc. D., State director on aging, Dec. 9, 1976. New Hampshire: Report of activities from New Hampshire State Council on Aging, Claira P. Monier, director, Dec. 9, 1976.

[17] Report cited in footnote 13.

[18] Report cited in footnote 8.

[19] Report cited in footnote 16.

[20] Report of activities from South Carolina Commission on Aging, Harry R. Bryan, director, Dec. 10, 1976.

[21] West Virginia: Report cited in footnote 16. Arkansas: Report cited in footnote 5.

A. Legal Services

Legal services programs for the elderly are beginning to take hold in many States. In some cases, special working arrangements have been made with other agencies to extend the legal services beyond an initial grant made available under the 1975 Amendments to the Older Americans Act, which established legal services as a priority service for the elderly.

In Alaska, title III of the Older Americans Act provided funding for 15 full-time, circuit-rider attorneys assigned to Alaska Legal Services. ACTION also provided funding for the project, as well as recruitment of attorneys.[22]

In California, an Older Americans Act model project grant is making possible paralegal training and technical assistance for California's elderly. The California Department on Aging contracted with the National Paralegal Institute of San Francisco to develop and provide training to 60 people, most over the age of 60, in procedures and legal aspects of supplemental security income, medicare, Medi-Cal (California's medicaid program), in-home supportive services, age discrimination, landlord-tenant problems, institutionalization, and protective services. The program is geared to develop skills in legal research, interviewing, negotiating techniques, and representation at administrative hearings. A second year of training is planned for an additional 100 people.[23]

Maine is in the second year of a statewide legal services for the elderly program, funded under title III of the Older Americans Act. The program employs six elderly VISTA paralegal assistants and one circuit-rider attorney. The paralegals work under the direction of a county cooperative extension service.[24]

B. Health Programs

Specialized health programs are being developed in several States.

Nevada reports two pilot county health programs to provide easier access for the elderly to medical treatment, rehabilitation services, health consultation, and education. The clinics provide outreach services to seek elderly who can participate and offer dental, opthalmology, podiatry, laboratory, and X-ray services.[25]

In Minnesota, a pilot dental care program for senior citizens, funded through an appropriation from the State legislature, is being offered to low-income elderly. Participants in the program choose their own dentist and the commission of public welfare contracts with the dental care providers for services provided. The project also will determine the cost and feasibility of a statewide dental insurance program for the elderly.[26]

In cooperation with the New Hampshire Division of Public Health, the New Hampshire Office on Aging is providing basic and ongoing

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[22] Report cited in footnote 11.
[23] Report cited in footnote 8.
[24] Report of activities from Bureau of Maine's Elderly, Richard W. Michaud, director, Nov. 19, 1976.
[25] Report of activities from Nevada Division for Aging Services, John B. McSweeney, administrator, Nov. 18, 1976.
[26] Report of activities from Minnesota Governor's Citizens Council on Aging, Ted Gredvig, assistant for administration, Dec. 1, 1976.

health screening to all those in the State over the age of 60. The services include screening for diabetes, glaucoma, blood pressure, and oral cancer.[27]

Wisconsin also reports that health screening programs funded under title III of the Older Americans Act are very popular.[28]

The Iowa Division on Alcoholism and Iowa Commission on Aging have jointly funded a study of alcoholism among the elderly. The study is meant to provide a base for a program designed to work with alcoholism among older Iowans. To date, the study has found that only 10 percent of alcoholism treatment centers in the country offer specific services to older persons, even though 67 percent of the alcoholism agencies surveyed throughout the country felt that the problem of alcoholism among the elderly was sufficiently critical to warrant special attention.[29]

C. Community-Based Services

A number of different approaches to community-based housing, or support services which can provide services in the home or in the community to allow many elderly to remain in their own homes, are being taken by a number of States.

Sheltered Housing.—A major effort in sheltered housing for the elderly is taking place in the State of Maryland. Senate bill 805, passed by the 1976 Maryland General Assembly, called for expansion of the duties of the Maryland Office on Aging to include the development and operation of a sheltered housing program for the elderly. According to the Maryland Office on Aging:

> Sheltered housing is a concept of residential living combining shelter, meals, and services. It provides older people, age 62 and over, who have temporary or periodic difficulties with the activities of daily living, with assistance in performing those personal and household functions associated with complete independence. These services fall into three categories: (1) three meals a day, (2) light housekeeping, and (3) personal services.[30]

Maryland now has 110 units of sheltered housing in operation. All are in existing housing facilities. A 4-year plan for the program projects 1,000 sheltered housing units in operation by fiscal year 1980.

Day Care.—Rhode Island reports the establishment of three day care centers for the elderly under title III of the Older Americans Act. According to the office on aging: "What is being experienced in Rhode Island is that ethnicity and income and life style is making the difference in how and what the day care clients need, want, and enjoy most." [31]

In Virginia, the 1976 general assembly passed a bill to encourage localities to evaluate the feasibility of geriatric day care programs under funding from title XX of the Social Security Act.[32]

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[27] Report cited in footnote 16.
[28] Report of activities from Wisconsin Division on Aging, Duane Williadsen, administrator, Dec. 16, 1976.
[29] Report of activities from Iowa Commission on Aging, Ronald W. Beane, acting director, Dec. 7, 1976, 1976 report, Commission on the Aging, State of Iowa, p. 21.
[30] Report cited in footnote 16.
[31] Report cited in footnote 6.
[32] 1976 General Assembly Legislation Affecting the Elderly, Final Report, April 1976, Virginia Office on Aging, Richmond, Va. HJR 20, SJR 23.

Live-In Help.—In West Virginia, a county senior citizens center will document the local need for live-in help, train individuals to meet the needs, identify sources of payment, and evaluate the satisfaction of the older person who is being served by the program.[33]

In-Home Services.—During 1976, the California Legislature appropriated $13 million from general funds for in-home supportive services for the elderly.[34]

Personal Care Residence.—In West Virginia, a college dormitory has been converted to a personal care residence with renovation of the building funded by a foundation, the Appalachian Regional Commission, and the West Virginia Commission on Aging. The residents of the newly renovated building will participate in all campus programs while students at the college will earn credits and experience in working with older persons in nursing, social work, recreation, nutrition, and sociology.[35]

Community Mental Health.—West Virginia is conducting a community mental health demonstration project to identify the needs of those elderly who might be sent to institutions if other alternatives are not available. The project is also developing alternative community care models. According to the director of the West Virginia Office on Aging, the project "grew out of the concern expressed by professionals in one community mental health center that 80 percent of the elderly referred to them for evaluation prior to placement in State mental hospitals did not need this type of institutional care." [36]

D. A Comprehensive State Plan

A major effort at a comprehensive, statewide, network of services for the elderly is underway in the State of Washington.[37] The 15-month model project is supported by an Administration on Aging model project grant and a State appropriation. A statewide comprehensive needs assessment survey was conducted and four new area agencies on aging were created to provide complete coverage throughout the State. The area agencies will administer a full range of services to the elderly including day care, in-home services, nutrition services, housing services, health screening, access services, night services, and volunteer programs through a retired senior volunteer program, a foster grandparent program, and a senior companion program.

Other demonstration projects contracted for by the Washington State Office on Aging under the model project include a mental health training program, a training program for counseling of the mentally ill, and a legal services project.

The statewide program is operated on a sliding-fee schedule that includes a percentage of cost of services provided for those above the 40 percent State median income level. The project is funded through December 1977.[38]

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[33] Report cited in footnote 16.
[34] Report cited in footnote 8. Assembly bill 2550, ch. 98, Apr. 6, 1976.
[35] Report cited in footnote 16.
[36] Report cited in footnote 16.
[37] Report cited in footnote 3.
[38] See part 2, appendix 4, item 1, for text of legislation passed by the Washington State legislature creating this program. Senior citizens services act, second substitute house bill No. 1316, signed into law Apr. 19, 1976.

III. LEGISLATIVE INITIATIVES

During 1976, the Colorado legislature established a legislative committee to study the problems and needs of older Coloradoans.[39] This action comes after much similar activity during 1974 and 1975, when 10 States established new joint legislative committees on aging or other legislative units which could give overall direction and attention to the needs of the elderly within the State.

A number of States reported significant legislative activity directly affecting older Americans, with efforts to provide some tax relief for the elderly and consumer protection measures most frequently reported.

A. Tax Relief

Legislatures in the following States took action to improve tax relief for the elderly during 1976:

Idaho raised the circuit-breaker tax exemption eligibility level to $5,500 for those age 65 and over in 1976.[40]

Alaska added a program of tax exemption for elderly renters to its current program of elderly property owner tax exemption.[41]

California voted $31 million in property tax relief to owners and renters, instituted new income tax exemptions for the elderly, and liberalized the senior citizen property tax assistance law.[42]

Hawaii raised property home exemption levels and increased tax credits for all low-income individuals.[43]

In West Virginia, new laws were signed in 1976 to make income up to $10,000 from pensions and annuities tax exempt for those over age 65 and to increase the inheritance tax exemption for widows and widowers.[44]

South Carolina passed legislation to establish a uniform mail procedure to be used by those over age 65 to reconfirm annually their eligibility for a homestead tax exemption.[45]

Iowa granted additional tax relief for the elderly and handicapped who own mobile homes and increased and extended property tax relief for the elderly.[46]

B. Consumer Protection

Eight States report the adoption or consideration of consumer protection laws in the areas of hearing aid regulation, generic drug substitution, and prescription drug price advertising, price advertising for eyeglasses, and measures to control utility rates for the elderly.

UTILITY LIFELINE RATES

Maine passed legislation to create demonstration lifeline electrical service projects for senior citizens.[47] North Dakota anticipates activity

[39] Report cited in footnote 16.
[40] Report cited in footnote 3.
[41] Report cited in footnote 11.
[42] Report cited in footnote 8.
[43] Report cited in footnote 4.
[44] Report cited in footnote 16.
[45] Report cited in footnote 20.
[46] Report cited in footnote 29.
[47] Report cited in footnote 24.

in the legislature this year to discuss utility lifeline rates for the elderly.[48]

GENERIC DRUG SUBSTITUTION AND PRICE ADVERTISING

The Nevada State Legislature Special Subcommittee on Aging Problems has developed recommended legislation regarding generic drug labeling and substitution.[49] In 1976, the Maine legislature passed legislation aimed at reducing prescription drug costs, including measures to allow prescription drug price advertising, to require generic name and price posting of the 100 most frequently used drugs, to permit substitution of generic equivalents, and to insure consumer representation on the board of commissioners of the profession of pharmacy. Maine's legislature has also passed a bill to conduct a legislative study to investigate expansion of the State's medicaid program to cover free drugs and prosthetic devices for more elderly, and to allow the Maine Department of Health and Welfare to carry on a free drug program for the elderly and poor if funds become available.[50]

In Virginia and Iowa, legislation passed in 1976 to permit generic drug substitution.[51] California enacted a bill allowing prescription drug price advertising, and West Virginia recently enacted a law to require prescription drug price posting of the 100 most commonly used drugs and to require disclosure, on request, of the price of any drug sold.[52]

HEARING AIDS AND EYEGLASSES

Legislation to regulate the hearing aid and eyeglass industry was also passed in a number of States during 1976. The Maine Legislature passed a bill to license hearing aid dealers and fitters,[53] and Virginia passed legislation to remove prohibitions against optometrist price advertising.[54]

In Arkansas, the Governor's Advisory Committee on Aging, along with the Arkansas Office on Aging, will present a legislative package to the legislature which will include provisions for hearing aid dealer regulation and repeal of a prohibition against eyeglass price advertising.[55] The Nevada Special Subcommittee on Aging Problems has also developed recommended legislation for the trade regulation of hearing aid specialists.[56]

NURSING HOME REGULATION AND PROTECTIVE SERVICES

Eight States reported activity in their State legislatures during 1976 to enact adult protective services legislation or to adopt State measures to strengthen inspection of nursing homes and other health facilities and train nursing home personnel.

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[48] Report cited in footnote 15.
[49] Report cited in footnote 25.
[50] Report cited in footnote 24.
[51] Virginia: Report cited in footnote 32. Iowa: Report cited in footnote 29.
[52] California: Report cited in footnote 8. West Virginia: Report cited in footnote 16.
[53] Report cited in footnote 24.
[54] Report cited in footnote 32.
[55] Report cited in footnote 5.
[56] Report cited in footnote 25.

In June 1976, New Jersey enacted a nursing home patients' bill of rights.[57] Under this legislation, nursing homes in New Jersey will be responsible for:

—Maintaining a complete record of all funds and possessions deposited by residents for safekeeping;
—Providing for the spiritual care of residents, if desired;
—Admitting only that number of residents which can be safely accommodated in the facility;
—Ensuring that no physical restraints are used, except upon written order of a physician, and that drugs are not used for purposes of punishment;
—Permitting members of certain groups which render assistance without charge to nursing home residents, full access to nursing homes at reasonable hours and under specific conditions;
—Ensuring compliance by the nursing home with all applicable State and Federal statutes and regulations; and
—Providing residents with a written list of services provided and related charges.

Nursing home patients will have the right to manage their own financial affairs; to wear their own clothing and keep their own possessions; to have mail delivered unopened, have access to a telephone, and be allowed personal visitation; to present grievances to the nursing home administrator; and to discharge themselves upon presentation of a written release, under certain circumstances. The bill also guaranteees nursing home residents the right to participate in the planning of their care; to refuse treatment or participation in experimental research; to refuse to perform services for the nursing home; to reasonable opportunity for interaction with members of the opposite sex; and to notice of nonemergency transfer or discharge at least 30 days before scheduled.

In Virginia, the 1976 general assembly adopted legislation to insure rights for nursing home patients;[58] Minnesota passed legislation in 1976 to require all nursing home employees to complete a training program, to establish an office of nursing home complaints in the department of health, and to expand the State's patient's bill of rights.[59]

In addition, legislatures in Alabama, Nevada, and Arkansas, according to the reports of these State offices on aging, will be considering protective services, patient's rights, and nursing home personnel training legislation in their upcoming sessions.[60]

In Maryland, legislation was passed to require the Maryland Office on Aging to encourage participation of citizens in the administration and programs of nursing homes. The Maryland Legislature also acted to require a geriatric evaluation of the elderly as a condition of admission to any mental institution. In addition, the legislature has requested the State office on aging to study the question of mental health and illness of the elderly in the State.[61]

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[57] Report of activities from New Jersey Division on Aging, James J. Pennestri, director, Dec. 6, 1976. For full text of Senate bill 944, see part 2, appendix 4, item 2.
[58] Report cited in footnote 32.
[59] Report cited in footnote 26.
[60] Alabama: Report of activities from State of Alabama Commission on Aging, Emmett W. Eaton, executive director, Nov. 18, 1976. Nevada: Report cited in footnote 25. Arkansas: Report cited in footnote 5.
[61] Report cited in footnote 16.

In South Carolina, legislation which was initiated by the legislative study committee on aging and passed by the legislature during 1976 will strengthen the adult abuse and protection law and provide a monetary penalty system for violations of hospital and nursing home licensing standards.[62]

C. Community Services

Other legislative activities reported include measures to improve access to health care, to improve coordination of services, and to finance housing for the elderly.

Health access.—In Minnesota, in addition to an appropriation for the pilot dental care program for the elderly discussed on p. 182, the legislature passed a law to require health insurance companies to make catastrophic benefits available to those who do not currently qualify because of existing health problems, to be partially financed by the State. Minnesota will also provide subsidies to local governments for community health services.[63]

In West Virginia, the legislature has enacted new legislation to establish and regulate a physician's assistant program, and to require the department of health to establish mobile health screening units for blood pressure, diabetes and tuberculosis.[64]

Transportation.—Rhode Island and California have enacted legislation to provide free transit services to the elderly and handicapped during off-peak hours, and North Dakota expects activity in the legislature this year to provide a statewide appropriation for transportation.[65]

Housing.—Housing for the elderly is a key issue in Alaska. During 1976, the State legislature passed a $7.5 million bond issue for housing for the elderly.[66]

The Minnesota Legislature passed a $21 million housing repair finance program, and earmarked $6 million of this amount for the elderly.[67]

The New Jersey Legislature passed a $90 million bond issue for construction and rehabilitation of housing for the elderly and low- and moderate-income families.[68]

Coordination of services.—The California Legislature created an office of food and nutrition within the Governor's office to develop a statewide nutrition plan and define priorities and coordinate all food and nutrition activities within the State government. The California Legislature also enacted legislation to establish minimum regulations for provision of supporting services to the elderly in multipurpose senior centers.[69]

In Hawaii, the State legislature delegated authority to the State office on aging for development of policies for senior centers throughout the State.[70]

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[62] Report cited in footnote 20.
[63] Report cited in footnote 26.
[64] Report cited in footnote 16.
[65] Rhode Island: Report cited in footnote 6. California: Report cited in footnote 8. North Dakota: Report cited in footnote 15.
[66] Report cited in footnote 11.
[67] Report cited in footnote 26.
[68] Report cited in footnote 57.
[69] Report cited in footnote 8.
[70] Report cited in footnote 4.

IV. ACTIVITIES OF NATIONAL ORGANIZATIONS

As the special concerns of the elderly become more apparent and more pressing on State and local officials, a number of national organizations which serve research and policy analysis needs of local governments have turned their attention to the development of program and legislative support materials directed at improving the capability of State and local governments to meet these needs. Activities of three of these organizations are discussed here.

A. Council of State Governments

The Council of State Governments is now into its second year of a project on aging intended to develop model State statutes on aging and prepare papers on specific issues in State programing for the elderly. The project prepared 17 suggested State statutes, and 5 were adopted by the council for publication and distribution to all State governments as "1977 Suggested State Legislation." The five statutes include a Public Guardian Act, a Multiservice Senior Center and Community Care Program Development Act, a Hearing Aid Dealers Regulation Act, a Health Care Facility, Safety and Security Act, and a Life Care and Payments Contract Act. The full text of these statutes are contained in a recent publication of the Council of State Governments.[71] The publication also summarizes 12 other State statutes which were considered by the council, and presents discussions of State activities in integrating services for the elderly at the community level, in tax policy for the elderly, and in transportation programs for the elderly.

In another publication, the Council of State Governments has published a review and analysis of State tax policy for the elderly and prepared cost estimation models for a number of forms of State tax relief.[72] According to the council, more than 30 States have now made provision for property tax relief for some or all elderly citizens. The publication discusses the various approaches to tax relief for the elderly, and notes that the homestead exemption making property of residence tax free up to a specific dollar value is the most common statute, with the circuit-breaker approach the second most utilized means of granting property tax relief.

In addition to these activities, the council is now undertaking a series of seminars on specific State issues in services for the elderly. A seminar on "Intergovernmental Planning in Services to the Elderly" was held in December 1976, and additional seminars on education and health are planned for later this year.

B. U.S. Conference of Mayors

The U.S. Conference of Mayors Task Force on Aging has collected data on 20 specific services for the elderly in 56 cities ranging in population from 50,000 to 2.5 million. Six priority areas emerged during

[71] The Older Americans: Issues in State Services, Council of State Governments, Iron Works Pike, Lexington, Ky., 40511, August 1976, $4.50.

[72] State Tax Relief for the Elderly: Determining the Costs, Council of State Governments, Iron Works Pike, Lexington, Ky., 40511, November 1976, $6.

the research: Crime, economic security, health, housing, senior centers, and transportation. The information collected about services has been published by the conference [73] and distributed to mayors and other local officials. A handbook designed for the use of urban officials in designing programs for the elderly has been published [74] with case studies of successful programs in these six priority areas as well as chapters on information and referral services and the role of the mayor in catalyzing and providing services to the elderly. The conference also publishes a quarterly newsletter, Seniors and Cities, with information on planning and programing in urban areas.[75]

In addition to these publications, the task force is preparing several seminars for mayors and other urban officials and planners to present and discuss a number of timely and innovative programs for the elderly in urban settings. These seminars will be held throughout the country during the coming year.

C. National Association of Counties

The National Association of Counties Research Foundation aging program is nearing completion of a program to build the capacity of county governments in serving the elderly. The NAC is publishing a series of case studies on county efforts in a number of areas, disseminating news and case studies of programing for the elderly in the association's weekly newsletter, "County News," and sponsoring a series of national conferences on county resource development for aging citizens throughout the country.[76]

Two of the case studies, "A Low Cost, Fare-Free Transportation Program for the elderly and Disadvantaged" and "Dade County's Program to House Elderly," have been published, and four more in the series will be published during the coming year. The programs to be discussed are a long-term care program in Pima County, Ariz.; the department for senior citizen affairs in Nassau County, N.Y.; the senior safety and security program of Cuyahoga County, Ohio; and the partnership between two counties in an office on aging for Douglas and Sarpy Counties, Nebr.

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[73] Services for the Urban Elderly in Selected Cities, U.S. Conference of Mayors Task Force on Aging, 1620 Eye St., NW., Washington, D.C., 20006, April 1976.

[74] Serving the Urban Elderly: Strategies for Mayors, U.S. Conference of Mayors Task Force on Aging, August 1976. Available from address above, $7.

[75] Newsletter available from the conference on a subscription basis.

[76] Subscriptions to County News and copies of the case studies are available from the National Association of Counties Research Foundation aging program, 1735 New York Avenue NW., Washington, D.C., 20006. The association maintains a mailing list for all its publications on programing for the elderly. The National Conference on County Resource Development for Aging Citizens is designed to present innovative programs for the elderly operated by county governments and is directed to county officials. The first conference was held in Washington, D.C., in early January 1977, and subsequent conferences will be held in Kansas City, Mo. in April 1977, and in San Diego, Calif., in June 1977.

CHAPTER XIII

IMPROVING LEGAL REPRESENTATION FOR OLDER AMERICANS

Previous committee reports have emphasized that legal services are vitally important for the elderly who rely—perhaps more than any other age group—upon Federal programs for their day-to-day activities.

But as things now stand, older Americans encounter many barriers in obtaining the representation they need—whether it involves counsel at a social security hearing, understanding technicalities about medicare, or drafting a will. In a very real sense, many aged persons now find themselves "friendless in the court."

Witnesses at earlier committee hearings [1] have cited several reasons for the underrepresentation of the elderly in our legal system:

—Many older Americans are priced out of the market for legal services—especially the moderate-income elderly—because they cannot afford to pay a private attorney $40 to $100 an hour, or whatever the going rate is. Large numbers are unaware of the legal services program, even though they may meet the income requirements.

—Some senior citizens are reluctant to apply for legal services because any means-tested program has a welfare stigma.

—Older Americans quite often have a tendency to be shy about seeking legal representation because "they do not want to be a burden on their families or society." Thus, there may be a tendency for the organized bar and the legal services program to overlook or perhaps ignore their needs.

—The private bar and the legal services program ordinarily has less expertise concerning the elderly's legal problems than other areas of law. In part, this is attributed to little or no law school curriculum on legal issues affecting older Americans.

—The fees for private attorneys are likely to be low, considering the expenditure of time and the complexity of the legal issues.

The net impact is that far too many older Americans accept erroneous decisions by programs administrators—and in some cases injustice—simply they do not know what recourse is available.

However, there were a number of positive developments in 1976 which may lead to improved legal representation for the elderly.

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[1] See "Legal Problems Affecting Older Americans," part 1, St. Louis, Mo., Aug. 11, 1970; part 2, Boston, Mass., Apr. 30, 1971; and "Improving Legal Representation for Older Americans," Los Angeles, Calif., June 14, 1974.

I. LEGAL SERVICES CORPORATION

First, the fiscal 1977 State, Justice, and Judiciary Appropriations Act [2] provided $125 million for the Legal Services Corporation, $31.67 million above the fiscal 1976 funding level of $93.33 million. The Ford administration, however, proposed to rescind $45 million from the fiscal 1977 appropriation, claiming the additional funds would be used to finance more attorneys and higher administrative costs for legal services programs. Since the Congress did not ratify the administration's proposed rescission, the money will be available during fiscal 1977. The corporation plans to direct $15 million of the additional funding to areas not served by legal services programs. In addition, the corporation plans to provide increased support to programs which are now underfunded.

Second, the corporation entered into 19 contracts to study alternative approaches for improving legal representation, including judicare, vouchers, prepaid plans, and contracts with private attorneys. One judicare model—sponsored by Utah Legal Services—will focus specifically on the needs of the aged. Three others will include senior citizens as a target group:

—Judicare of Anoka County (Minn.), Inc., will test out a judicare plan for clients.

—Legal Aid Society of Birmingham will contract with private attorneys to provide specific types of services, including drafting of wills and testamentary documents for the elderly.

—Group Legal Services, Inc., will test the use of prepaid legal services for low-income persons in Los Angeles County.

Third, the corporation and the Administration on Aging reached an agreement to encourage cooperative efforts between local area agencies on aging and legal services programs. A major effort will be made to inform older Americans about the availability of legal services.

Fourth, the corporation plans to assign a person to AoA to strengthen legal representation on behalf of the elderly.

Fifth, legal services programs now receive about $1.7 million from the title III State and community programs on aging under the Older Americans Act. Approximately 22 percent of the legal services projects—or 56 out of the 258 funded by the Legal Services Corporation—receive supplementary funding from the Older Americans Act.

II. ADMINISTRATION ON AGING

The 1975 Older Americans Amendments [3] gave AoA new responsibilities for strengthening legal representation for the aged. Public Law 94–135 identifies four priority services—including legal counseling, transportation, home health, and residential repairs—for funding under title III. Title IV is also broadened to include the training of lawyers and paraprofessionals to (a) provide legal counseling or (b) monitor the administration of programs for older Americans.

[2] Public Law 94–362, approved July 14, 1976.
[3] Public Law 94–135, approved Nov. 28, 1975.

Nearly $1.2 million is now available for 11 section 308 model projects to fulfill 3 primary goals:

(1) Encourage the inclusion of a legal services component within each of the comprehensive coordinated services structure developed by State and area agencies on aging.

(2) Insure that legal services activities can be staffed with trained professional and paraprofessional personnel.

(3) Develop innovative projects to work with State and local offices on aging.

Major activities under section 308 include:

Legal Research and Services for the Elderly (National Council of Senior Citizens) provides technical assistance in a 20-State area east of the Mississippi River. LRSE has been actively involved in developing statewide legal services programs by drafting model State statutes, providing literature about the special legal needs of the elderly, and developing training programs. LRSE has also prepared a handbook, "The Law and Aging Manual," which is designed to assist the practitioner in the field of aging, legal services attorneys, and aged clients.

National Senior Citizens Law Center provides technical assistance in 29 States. A nursing home newsletter is published monthly, and a weekly newsletter provides helpful information concerning legislative and administrative developments in the field of aging. In addition, NSCLC has prepared "A Manual of Funding Sources and Models for Delivering Legal Services to the Elderly."

Legal Counsel for the Elderly (National Retired Teachers Association-American Association of Retired Persons) provides a wide range of benefits for elderly clients in the Nation's Capital, including information and referral, a "checkup" concerning public benefit programs, and consultation on legal problems.

AoA has also funded six projects under title IV at a $700,000 level to train lawyers and paraprofessionals to provide competent representation for aged clients. The George Washington University National Law Center is developing new teaching materials on law and aging. And, the University of Michigan is developing materials to sensitize professionals in law and education about the needs of the elderly. This includes gerontological concepts for in-service training of lawyers and community college faculty.

AoA estimates that approximately 100 area agencies on aging have contracted with service providers to make legal representation available for older Americans. Nearly $2.5 million is committed for this purpose. In January 1977, AoA provided $1.25 million to State offices on aging to promote and develop legal services. A major objective is to encourage the establishment of a legal services project in every planning and services area throughout the country.

III. COMMITTEE ON AGING HEARINGS

Three hearings [4] conducted by the Committee on Aging provided fresh new perspectives about the legal problems of the elderly. At a

[4] "Improving Legal Representation for Older Americans," part 2, Boston, Mass., Aug. 30, 1976; part 3, Washington, D.C., Sept. 28, 1976; part 4, Washington, D.C., Sept. 29, 1976. Hearings are not in print.

hearing in Boston, conducted by Senator Kennedy, witnesses—including elderly clients, legal services attorneys, senior citizen leaders, and a member of the Massachusetts Bar Association—emphasized that many older Americans now find themselves in an impossible situation when a legal problem arises. Senior citizens also discussed in moving terms the problems they encounter with Federal benefit programs and Government agencies.

One elderly woman in a public housing project paid $16 for an electric heater because her apartment was too cold in the winter. And when the temperature became unbearable, she moved in temporarily with a relative.

Senior citizen leaders, as well as legal services attorneys, emphasized the important role of paralegals in counseling older Americans. They also stressed that some elderly paralegals may be more effective in assisting aged clients under certain circumstances than private attorneys.

Mr. Robert Spangenberg, a member of the Massachusetts Bar Association and a former executive director of Action Plan for Legal Services, described a study on the legal needs of low-income persons in the Boston area. About 16 percent of the families interviewed were elderly. Housing and income maintenance represented the two most serious problems for aged Bostonians. Major problem areas in housing included evictions, rent increases, and code violations. Mr. Spangenberg added:

> We found that—which I am sure is no surprise—that there are many low-income citizens in the city of Boston who qualify for SSI benefits, and were either not aware of the fact that they qualified or are not aware of what the qualifications are for SSI. There is a large number of the elderly population who with some assistance and education should be receiving the public benefits that the Commonwealth set forth and are not at the present time.[5]

Two hearings in Washington[6] provided additional insight about the legal problems affecting the elderly. David Marlin, director of Legal Research and Services for the Elderly, projected that about 200,000 older Americans are now served by Legal Services Corporation and Legal Aid offices, law school clinics, and AoA-funded programs. But he estimated that nearly 5.8 million may need legal help, giving this analysis:

> As the current population of persons 65 and over is in excess of 22.3 million, over 22 million older persons still remain in the potential client population. Discounting the 30 percent with incomes presumptively sufficient to retain a private attorney, 15.6 million remain. As the American Bar Foundation estimates that 37.3 percent of the adult population will face a legal problem each year, a conservative estimate of the number of older persons per year who face imminent legal

[5] "Improving Legal Representation for Older Americans," part 2, Boston, Mass., Aug. 30, 1976, p. 168.
[6] See footnote 4.

action but are without access to essential legal representation is 5.8 million.[7]

Reasonable persons may disagree as to the actual number of older Americans who cannot obtain the legal assistance they need. But there is little doubt that many must shift for themselves when a legal problem arises.

Paul Nathanson, executive director for the National Senior Citizens Law Center, noted that nearly 100 legal services programs are now funded under title III of the Older Americans Act, but average fewer than 2 attorneys per project. He concluded that AoA lacks the sufficient funds to shoulder the burden of providing legal services for older Americans. Barring any major policy shift, AoA will not possess the resources to achieve this objective—even if projects funded by the Legal Services Corporation would also be included.

Mr. Nathanson then discussed some alternative funding sources to make legal representation more readily available:

—Filing fee legislation—already enacted in Florida, Oregon, and Nevada—generates revenue for legal services programs by imposing additional fees on pleadings and papers filed in court.

—Lawyer referral services now exist in Orange County, Calif., and generates $160,000 a year. Consultation fees—ranging from $10 to $15, depending upon the client's income—are donated to the legal services program to supplement funding from the Legal Services Corporation.

Thomas Erlich, president of the Legal Services Corporation, concluded that much of the work performed by legal services projects has a direct and substantial impact upon older Americans, but it still falls far short of the demonstrated need. He said:

> The point is clear: A great deal of work done by programs funded by the Legal Services Corporation has a direct and substantial impact upon elderly persons, regardless of whether they also receive service as individual clients. For this reason no statistics can reflect accurately the extent to which legal services programs serve the elderly.
>
> Nonetheless, we do not suggest that we are presently meeting the needs of the elderly poor for legal services. There are too few resources devoted to insuring equal access to justice for the elderly, just as there are for poor people in general. With respect to the elderly, however, the problems of too few lawyers and too few programs are compounded by lack of physical access to legal services. Many elderly people are less mobile than other members of the population and may be less well informed regarding the availability of free legal services and the ways that such services can help them. Access may be particularly difficult for persons who became poor late in life and live many miles from the ghetto areas in which legal services offices are typically located.[8]

Mr. Erlich said that the corporation plans to take two actions to overcome these problems. Additionally, he hopes that the Congress

[7] "Improving Legal Representation for Older Americans," part 4, Washington, D.C., Sept. 29, 1976. Hearing is not in print.
[8] Testimony at hearing cited in footnote 7.

will implement the Committee on Aging's recommendation to increase funding for the corporation.

First, the corporation plans to coordinate the expertise of legal services programs with that of agencies knowledgeable about the problems of older Americans. He cited cooperative efforts with AoA as an example.

Second, the corporation plans to train more service providers, particularly paralegals, in areas of direct concern to the elderly. Mr. Erlich added:

> Our office of program support is currently making plans to train more attorneys and paralegals for legal services work—including many areas that affect the elderly—than has ever been done before on a national level.[9]

Witnesses also offered several innovative recommendations to strengthen legal representation. Mr. William Fry, director of the National Paralegal Institute, suggested that perhaps a new title should be created under the Older Americans Act to provide earmarked funding and programmatic direction concerning the legal needs of the elderly.

Several recommendations were also proposed by Mr. Marlin. He suggested that the Congress should direct the Legal Services Corporation to prioritize its services to aged clients relative to their proportion of the poverty population. This would mean that older Americans would account for about one out of every four clients in the legal services program, since the 65-plus age group represents almost 24 percent of the entire adult poverty population. One way to implement this mandate, Mr. Marlin suggested, is to develop within each legal services project a special unit to be sensitive to the legal needs of the aged poor.

Mr. Erlich, however, opposed efforts to earmark funds to provide specialized services to the aged, giving this rationale:

> We do not recommend that funds be earmarked to provide specialized services to the elderly. The corporation's mandate is to provide service to all of the poor, concentrating only upon those least able to afford such service. Earmarking funds for any group would inevitably mean less efficiency in working toward that goal. It would mean that other clients or groups would be denied access to the legal system altogether. Such trade-offs should not be necessary when the sound solution is to provide the corporation with sufficient resources to perform the job for which Congress established it.[10]

Mr. Marlin further emphasized that the private bar must be encouraged to fulfill its articulated professional responsibility of providing public interest legal services. He cited a survey by the Wisconsin Institute for Research on Poverty which revealed that 60 percent of the lawyers devoted less than 5 percent of their billable hours to public interest work and nearly half spent no time at all for this purpose. Mr. Marlin suggested that perhaps private prac-

[9] Testimony at hearing cited in footnote 7.
[10] Testimony at hearing cited in footnote 7.

titioners should be allowed a charitable deduction when they render services to or through a tax exempt organization—after the lawyers have provided 100 nondeductible hours per year of pro bono services.

Finally, he recommended that a portion of the appropriations for the Legal Services Corporation, the Law Enforcement Assistance Administration, the Older Americans Act, and other relevant legislation be earmarked for educational programs concerning the legal rights and problems of the elderly.

IV. HOW AN "ADVOCACY CENTER" WORKS

In testimony before Senator Harrison Williams, Ms. Lessie Hill described how an advocacy center operates in a five-county area in southern New Jersey.[11] The Senior Citizens Advocate Center was first established in 1974 to provide free legal services to low-income persons 60 or older (incomes not exceeding $3,000 for individuals and $3,500 for couples). Funding is derived from two sources: Title III of the Older Americans Act and the Camden legal services program.

The center is staffed by two attorneys, two paralegals, law students, college students, senior volunteers, a VISTA attorney, and a VISTA paralegal. It provides legal assistance to about 780 indiviuals a year. In addition, 25 to 35 groups of clients are helped on a wide range of issues, such as landlord-tenant relations.

Staff attorneys provide legal representation and counseling on several matters of direct importance to low-income persons, including supplemental security income, social security, housing problems, protective services, domestic relations, estate planning, and the drafting of wills. Paralegals represent elderly clients before administrative agencies and provide information about Federal programs designed to serve the aged. Staff members also perform extensive outreach activities to alert older New Jerseyites about Federal benefits to which they are legitimately entitled.

Ms. Hill described several actions taken by the advocate center to assist elderly clients. Among the examples cited:

—Living conditions were unsuitable for elderly tenants at a public housing project in Camden. The dissatisfied occupants then organized a tenants association and asked the Senior Citizens Advocate Center to represent them. Through these combined efforts the tenants obtained new stoves, sinks, and refrigerators. The elevators, which had been hazardous for the occupants, were repaired and overhauled. In addition, the housing authority made arrangements to paint the apartments.

—Several senior citizens were informed by an owner of a mobile home park that their leases would be canceled in 6 months. The Senior Citizens Advocate Center represented these elderly clients and obtained a 6-month extension. This provided valuable time for them to sell their mobile homes or to locate apartments.

[11] "Improving Legal Representation for Older Americans," part 3, Washington, D.C., Sept. 28, 1976. Hearing is not in print.

V. GROUP PREPAID LEGAL SERVICES

The 1976 Tax Reform Act [12] includes a provision which is expected to encourage the growth of employer-financed prepaid legal service plans. An estimated 1.25 million to 1.75 million workers are now entitled to this fringe benefit. Depending on the structure of the specific group legal services plan, an employee paid a tax under prior law on either (1) the share of the employer's contributions to the plan on his or her behalf, or (2) the value of legal services or reimbursements received. The Tax Reform Act excludes from an employee's income both employer contributions and benefits received under qualified group legal services plans.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Competent and effective legal representation is a high priority need for aged and aging Americans. However, many elderly persons encounter formidable barriers when they seek legal assistance.

Some progress, to be sure, has been made under programs funded by the Legal Services Corporation and the Administration on Aging. These efforts should be continued and expanded. The Legal Services Corporation's study on alternative methods to improve the delivery of legal services also offers the prospect for improved legal representation for the elderly.

But existing efforts clearly fall short of the documented need. The committee recommends that the following steps be taken as early as possible to make legal representation more readily available for older Americans:

- **—Funding for legal services under the Older Americans Act and the Legal Services Corporation should be expanded in fiscal 1978.**
- **—AoA and the Legal Services Corporation should take prompt action to expand existing efforts to sensitize law schools and the private bar about their responsibilities concerning the legal needs of the elderly.**
- **—AoA and the Legal Services Corporation should continue innovative steps on behalf of elderly clients, including judicare, prepaid legal plans, the use of retired attorneys, and others.**
- **—The training of paralegals should be bolstered.**
- **—AoA should submit to the Congress comments about the desirability or undesirability of a special title under the Older Americans Act to focus on the legal needs of the elderly.**
- **—A portion of the funding for the Legal Services Corporation, the Law Enforcement Assistance Administration, and the Older Americans Act should be earmarked for educational programs concerning the legal rights and problems of the aged.**

[12] Public Law 94–455, approved Oct. 4, 1976.

CHAPTER XIV

MIDWAY BETWEEN WHITE HOUSE CONFERENCES ON AGING?

Delegates to the White House Conference of December 1971 issued recommendations for a broad range of actions on issues of concern to older Americans.

More than 5 years have passed, and the time has now come to consider whether another White House Conference on Aging should be held in 1981 or perhaps even 1980.

Senator Frank Church, chairman of this committee, has already begun to solicit opinions on the purposes and form of such a conference. Legislation now under consideration would call for early action to assure that adequate time for the preparations and assembling of essential information.

At what may be a midway point between such conferences, this report presents a brief summary of progress made since 1971 on a few selected issues. This committee urges that a more exhaustive effort at evaluation [1] be made as a built-in feature of preparations for the next White House Conference on Aging if, as now appears probable, one is to be held within the next 4 to 5 years.

I. INCOME IN 1971 AND 1976

Income was the No. 1 concern of the delegates attending the 1971 White House Conference on Aging. And it is still the most pressing problem affecting older Americans 5 years after the White House conference.

Delegates at the income section called for a comprehensive approach to improve the economic well-being of aged and aging Americans. Among the major recommendations:

(1) The elderly should have a total cash income in accordance with the intermediate budget prepared by the Bureau of Labor Statistics. (See p. 3 for more details.)

(2) A basic floor should be built under the income of the aged.

(3) The earnings limitation under social security should be increased to at least $3,000, and the $1-for-$2 reduction should apply to earnings above the exempt amount.

(4) Widows should be eligible for social security benefits at age 50, instead of 60.

(5) The financing of social security should include a contribution from general revenues. The payroll tax structure should be reviewed to lighten the burden of low-income workers.

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[1] During 1976, the Administration on Aging prepared one such evaluation at the request of Representative William Randall, then chairman of the House Select Committee on Aging. This was a useful document, but it stands in need of additional information and discussion.

(6) The private pension system should be strengthened to encourage broader coverage, require earlier vesting, and provide protection from loss of pension benefits through reinsurance.

Older Americans have probably registered more impressive gains on the income front than any other area since the White House Conference on Aging. But far-reaching actions are still urgently needed if our Nation is to solve the retirement income gap that affects millions of senior citizens and threatens to engulf many more.

Social security benefits have increased by 53 percent since the White House Conference on Aging. In addition, other important improvements have been enacted into law, including a new special minimum monthly benefit [2] for persons with low lifetime earnings and long periods of covered employment,[3] approximately a $1 billion increase in benefits for almost 3 million aged widows in 1973, and establishment of a cost-of-living adjustment mechanism to protect older Americans from inflation. In 1977, social security beneficiaries under age 72 will be able to earn $3,000 annually before their benefits will be reduced. For earnings in excess of this amount, $1 in benefits will be withheld for each $2 of earnings.

A new supplemental security income program [4]—although still plagued with some administrative problems and computer foulups—guarantees all aged individuals at least $167.80 a month and elderly couples $251.80 a month.

Private pension coverage has been improved with the enactment of the Employee Retirement Income Security Act.[5] Qualifying pension plans must meet one of three minimum standards for vesting: (1) Full vesting for employees after 10 years of participation in the plan; (2) 25 percent vesting after 5 years of participation—increasing 5 percent annually for the next 5 years, then by 10 percent per year until full vesting is reached at 15 years; and (3) a "rule of 45" under which employees with at least 5 years of service will have their pensions 50 percent vested when their age and years of service equal 45. A new Pension Benefit Guaranty Corporation now provides protection against pension plan failures. Guaranteed basic benefits are limited to the actuarial value at the time of termination of a monthly benefit in the form of a life annuity beginning at age 65, equal to the lesser of $750 or 100 percent of a participant's high consecutive 5-year average monthly gross income. The $750 limit (in 1976, it was $869.32) is to be adjusted by changes in the social security maximum taxable wage base. Pension plans are required to have a joint and survivor provision. The survivor annuity must not be less than one-half the annuity payable to the participant. And this provision applies automatically unless the employees elect otherwise. Individuals not now covered by a qualified pension or Government plan can establish their own pension and claim a tax deduction (individual retirement account). In addition, the tax deduction for Keogh plans has been liberalized for self-employed persons.

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[2] Social security benefits increased by 20 percent in 1972, 11 percent in two stages in 1974, 8 percent in 1975, and 6.4 percent in 1976. The aggregate for all these benefit increases is 53 percent because of the compound effect of adding one on top of another.

[3] The special minimum monthly benefit is now equal to $9 times the number of years of covered employment after 10 but not greater than 30 years.

[4] Public Law 92-603, approved Oct. 30, 1972.

[5] Public Law 93-406, approved Sept. 2, 1974.

Congress enacted legislation [6] to provide a 10-percent credit on the first $4,000 of earnings for low-income wage earners who maintain a household for a child (either under 19 or a student) or a disabled dependent adult. The credit is reduced by $1 for each $10 of adjusted gross income above $4,000 until it is eventually phased out at $8,000.

Nearly 1 million older Americans have been removed from poverty since the White House Conference on Aging. But more than 6 million live in poverty under a revised measure of poverty. And our Nation still falls far short of assuring income consistent with the BLS intermediate budget for older Americans.

II. HEALTH IN 1971 AND 1976

Health care as a basic right was supported by delegates discussing health issues at the White House conference. The delegates agreed that a comprehensive system of appropriate health care should be accessible to all older Americans. Such a system should provide the following:

—Assessment of health.
—Education to preserve health.
—Appropriate preventive and outreach services.
—All physical, mental, social, and supportive services necessary to maintain or restore health.
—Rehabilitation.
—Maintenance and long-term care when disability occurs.

The delegates made several recommendations to implement those objectives, including:

—The placement of special emphasis on the health care problems of, and services for, the aging.
—The enactment of a comprehensive national health insurance program, to be preceded by an expanded and improved medicare program.
—The establishment of a Presidential Commission on Mental Illness and the Elderly.
—The creation of a Center for the Mental Health of the Aged within the National Institute of Mental Health with authority and funds for research, training, and innovative programs for older people in the community and in hospitals.
—Strengthening medicare and medicaid with respect to reimbursement of mental health services.
—Federal supervision and enforcement of the use of medicaid funds.
—Increase research moneys for studies of aging and the elderly, from basic biological processes to social and psychological phenomena.
—The implementation of financing of a national policy on long-term care needs.

Since 1971, the following steps have been taken to reach these objectives:

—The establishment of a National Institute on Aging (Public Law 93–296) for the purpose of encouraging biomedical, behavioral, and social research and training relating to the aging process.

[6] Tax Reduction Act of 1975 (Public Law 94–12, approved Mar. 29, 1975) as amended by the Tax Reform Act of 1976 (Public Law 94–455, approved Oct. 4, 1976).

—Creation of a Center for the Mental Health of the Aged within NIMH in August 1975 with authority to coordinate research activities. (For more detailed explanation, see chapter VIII, section II, of this report.)
—In July 1975, the Congress established a temporary Committee on Mental Health and Illness of the Elderly to study the special problems of older Americans and report their findings to the Congress.
—In February 1977, President Carter created a Presidential Commission on Mental Health, naming Mrs. Carter as the honorary chairperson.
—In 1972, medicare coverage was expanded to include coverage of the disabled.
—Demonstration programs for home health and day health facilities have been established by the Congress to determine if these are suitable options to institutional care for elderly persons with debilities.
—The creation of an Office of Inspector General within HEW with oversight responsibilities for programs administered by HEW, including medicare and medicaid.

Despite the increased awareness of the health problems of the aged, medicare covers only about 42 percent of the elderly's health care costs. The part B (medical services) premium has increased from $5.60 per month in 1971 to $7.20 in 1976. Further, the part B deductible has increased from $50 to $60. Under part A (hospital services) the deductible has more than doubled—from $60 in 1971 to $124 in 1977.

Investigations by this committee have also revealed rampant fraud and abuse by medicare and medicaid practitioners (see chapter II of this report), resulting in increased Federal costs but no added benefits for the elderly an low-income users of the program.

Research and the development of innovative and more appropriate types of care for the elderly continue to be underfunded. The need for improvements in all health care aspects for the aged is great. Even though there have been some improvements, the overall situation is basically the same as existed in 1971—despite the need for comprehensive improvements on several fronts.

III. THE OLDER AMERICANS ACT IN 1971 AND 1976

The organizational structure for providing services to older Americans was a major concern of the delegates to the 1971 White House Conference on Aging. The Older Americans Act was seen as the logical vehicle upon which to build a sound and effective service delivery system for the elderly.

Delegates attending sessions on planning, facilities, programs, and services stressed the need for a much more comprehensive services system with greater status within the Federal Government bureaucracy. Their recommendations included:

(1) The establishment of a unit within the Executive Office of the President with responsibility for coordination, planning, and advocacy;

(2) The establishment in each community of a public senior service system including multipurpose senior centers;

(3) Substantial Federal funding for comprehensive nutrition programs geared toward eliminating malnutrition among the elderly;

(4) Federal funding for the construction of multipurpose senior centers; and

(5) Development of multidisciplinary research and training centers in gerontology.

Since the White House Conference on Aging, substantial gains have been made in fulfilling the conferees' recommendations. Total funding for the Older Americans Act increased from the Nixon administration's budget request of $29.5 million in 1971 to $401.6 million for 1977. The act has been amended four times to include additional categorical and emphasis service programs.[7]

At the Federal level, the Administration on Aging has become a more effective advocate and coordinator of services for the elderly. But AoA still falls far short of what the delegates sought. Various sections at the 1971 White House conference recommended that AoA be headed by an Assistant Secretary for Aging. AoA is no longer a part of the welfare-oriented Social and Rehabilitation Service, as it was in 1971. But it is under the direction of the Office of Human Development which is an intermediate unit between AoA and the Office of the Secretary.

President Carter, while campaigning for the Presidency, promised to create a White House Counselor on Aging to coordinate existing programs and to develop new initiatives to help the elderly.

Every State now has an agency on aging. In addition, there are approximately 500 area agencies on aging located throughout the country. The area agency acts as the coordinator of services for a geographical area. Its chief function is to develop a comprehensive service system for the elderly. AoA projects that by the end of 1977, 545 area agencies will be approved.

The title VII nutrition program for the elderly has grown in support and effectiveness. With an operating level of $225 million for fiscal year 1977, title VII projects are located in 809 communities in every State with over 6,000 sites serving around 300,000 meals daily. With the increased 1977 funding, AoA estimates that the projects will be capable of serving about 400,000 to 410,000 meals per day by the end of fiscal year 1977.

Multipurpose senior centers were first authorized in the 1973 amendments to the Older Americans Act (Public Law 93-29), but funding was not approved until fiscal year 1976 when the Congress provided $5 million for senior centers for the 1976 transitional quarter (June 30, 1976 through September 30, 1976). For fiscal year 1977, Congress approved $20 million for title V for the acquisition, alteration, or renovation of facilities to be used as a senior center.

Research and training efforts under the Older Americans Act were increased from $5.8 million in 1971 to $26.5 million in 1977 for training, research, and multidisciplinary centers of gerontology.

The multidisciplinary centers were supported for the first time in 1976 with an appropriation of $1 million for the 1976 transitional quarter and $3.8 million for fiscal year 1977. These funds can be used

[7] The Older Americans Act was amended in 1972 (Public Law 92-258), 1973 (Public Law 93-29), 1974 (Public Law 93-351), and 1975 (Public Law 94-135).

by nonprofit agencies, organizations, or institutions which must recruit and train personnel, conduct basic and applied research, provide consultation, serve as a repository of information, help to develop training programs, and create opportunities for teaching research and demonstration projects.

IV. HOUSING IN 1971 AND 1976

Delegates to the White House Conference on Aging recommended the development of a national policy on housing for the elderly which embraces "not only shelter, but needed services of quality that extend the span of independent living in comfort and dignity, in and outside of institutions, as a right wherever they live or choose to live."

More specifically, they recommended the following:

—The production of at least 120,000 units of housing for the elderly annually.

—A variety of living arrangements be made available to meet the changing needs of elderly persons.

—Emphasis be given to providing more congregate housing for the elderly.

—Local property tax relief for the elderly homeowner.

—The encouragement of neighborhood preservation and rehabilitation.

—The restoration of the highly effective section 202 program.

—Expansion of the rent supplement program.

—Financial incentives to families caring for elderly relatives in their own homes.

—The establishment of an Office of Assistant Secretary for Housing for the Elderly within the Department of Housing and Urban Affairs.

—The development of training programs for the managers of housing for the elderly.

Since 1971, various actions—both positive and negative—have been taken which affect housing for the elderly. One important development, and by far the most detrimental, was the imposition of a moratorium in January 1973 on the production of housing for low-income persons by President Nixon. This moratorium—preceded by impoundment of crucial housing funds—successfully halted housing production for several years. As a result, the Government has failed to produce anything remotely close to 120,000 units of housing for the elderly in any year since 1971. The Congress has, however, overturned the moratorium and reestablished Federal housing programs, but the implementation of these programs has proceeded at a slow pace.

The following action has been taken on the delegates recommendations:

—The Congress reactivated the successful section 202 program at a level which should produce 35,000 units of housing for the elderly annually. In addition, it is mandated that these developments include necessary service components and be architecturally barrier-free.

—Nearly every State has enacted property tax relief programs for the elderly. Unfortunately, two States which initiated programs have now repealed them.

—The section 8 rental assistance program has been implemented.
—An Assistant to the Secretary for Housing for the Elderly and Handicapped was created within the office of Housing and Urban Development in 1972. Unfortunately, this office was downgraded during 1976 to consist of a departmental adviser within the Office of Consumer Affairs at HUD.
—HUD has formed working agreements with the Administration on Aging and the Department of Transportation to narrow the gap between services and housing.
—HUD is developing certification programs for managers of federally assisted housing to improve the quality of housing managers. But, no special emphasis is placed on managing housing for the elderly.

Despite these changes, waiting lists for senior citizen housing are commonly 2 years long and many elderly persons continue to pay more than they can reasonably afford for rent. There is a desperate need for the prompt and speedy implementation of the Housing Act of 1974 and the Housing Act of 1976. Further integration of services is also crucial if elderly persons are to remain in independent and semi-independent settings.

V. EMPLOYMENT IN 1971 AND 1976

Delegates at the Employment and Retirement Section said:

> Our long established goal in employment and retirement policy is to create a climate of free choice between continuing in employment as long as one wishes and is able, or retiring on adequate income with opportunities for meaningful activities.[8]

The delegates further emphasized that several barriers exist, preventing the implementation of a national employment policy for older workers.

The Employment and Retirement Section called for several actions to provide greater employment opportunities for older workers, including:

(1) Funding must be earmarked to improve job opportunities for older workers.

(2) Federal, State, and local manpower programs should expand their services and provide more job recruitment, training, counseling, and placement services for older workers.

(3) The age-65 year limitation for the Age Discrimination in Employment Act should be removed, and the act should cover all employees in the private and public sectors.

(4) The Government should assume the role of the "employer of the last resort" for older workers willing and able to work.

(5) Preretirement counseling should be provided locally throughout the Nation by trained instructors, at least 5 years before normal retirement.

[8] "1971 White House Conference on Aging: A Report to the Delegates from the Conference Sections and Special Concerns Sessions," 92d Cong., 1st Sess., S. Doc. 53, December 1971, p. 4.

Some progress has been made in implementing the employment recommendations of the White House Conference on Aging. However, the achievements have fallen far short of the stirring call for action urged by the Employment and Retirement Section. A senior community service employment program was enacted into law in 1973 as a part of the Older Americans Comprehensive Services Amendments.[9] Approximately 15,000 low-income persons 55 or older now participate in the program. And the figure is expected to reach 22,600 when the funding level reaches $90.6 million for the period July 1, 1977 to June 30, 1978.

Coverage under the Age Discrimination in Employment Act is now broadened to include governmental employees.[10] In addition, employers with 20 or more employees (formerly 25) are subject to the provisions of the law.[11]

Some improvements have been made in the proportion of older workers participating in Federal manpower programs. But by any objective measuring standard, they are still underrepresented. In addition, false stereotypes exist about the desirability or employability of older workers. Many have also discovered that their skills are outdistanced by technological advantages. Large numbers have also been automated out of a job. The harsh reality is that our Nation still lacks a clear-cut, effective policy to promote job opportunities for older workers, despite the compelling call to action by the White House Conference on Aging.

VI. ELDERLY MINORITY GROUPS IN 1971 AND 1976

Four special concerns sessions at the 1971 White House Conference on Aging focused on the special problems of aged minority groups; elderly Asian-Americans, blacks, Indians, and Spanish-speaking persons. Several common themes emerged from these four sessions, despite cultural and other differences among these groups. All agreed that the minority aged suffer greater intensity of deprivation than older anglos. There was also widespread agreement that far too little attention has been devoted to the minority aged's special needs. In addition, the groups emphasized the need to develop more complete and accurate data to enable policymakers to make key decisions on issues affecting aged Asian-Americans, blacks, Indians, and Spanish-speaking persons.

A priority proposal in practically every case was the need for a guaranteed annual income, ranging from $6,000 for individuals and $9,000 for couples at the aged and aging blacks special concerns session to $3,375 for single persons and $4,500 for married persons at the Spanish-speaking elderly meeting.

The minority groups also focused on unique problems confronting them. The elderly Indians, for instance, urged that the Older Americans Act be amended to permit direct funding of Indian tribes. The Asian-Americans recommended that food assistance programs should take into account their cultural differences. An earlier eligibility

[9] Public Law 93–29, approved May 3, 1973.
[10] Public Law 93–259, approved Apr. 8, 1974.
[11] Public Law cited in footnote 10.

age for social security benefits was proposed for aged black males and elderly Spanish-speaking persons because of their shorter life expectancy.

Elderly minority groups have benefited from enactment of several measures affecting older Americans, including:

—Social security increases;
—The establishment of a cost-of-living adjustment mechanism for social security and the supplemental security income program;
—Creation of SSI;
—Establishment of a national hot meals program for older Americans at conveniently located centers;
—Extension of medicare coverage to disabled social security beneficiaries.

However, the needs of elderly minority groups are so great that considerably more needs to be done before the next White House Conference on Aging. In addition, the proposals for special actions have produced few concrete results. One exception is that the Commissioner on Aging is now authorized to provide direct funding of Indian tribes under title III upon a determination that (a) Indian tribe members are not receiving benefits equivalent to other older persons in the State, and (b) they would be better served through direct funding.[12]

VII. LEGAL SERVICES IN 1971 AND 1976

The Legal Aid and the Urban Aged Special Concerns Session at the 1971 White House Conference on Aging developed a number of recommendations to strengthen legal representation for older Americans, including:

—Federal funding to train elderly laymen as paid legal aides and to operate programs in which these aides can act as advocates on behalf of older Americans before administrative agencies.
—An assurance that the board of directors of the legal services agency would include elderly representatives approximately proportionate to the aged's share of the poverty population.
—Establishment of a special center concerning legal rights of the elderly.

Several concrete actions have occurred during the past 5 years to implement some proposals of the White House on Aging delegates and to strike out in new directions. A support center focusing on the legal needs of the elderly (the National Senior Citizens Law Center) was funded in 1972. The National Senior Citizens Law Center provides technical assistance for legal services offices representing aged clients. In addition, NSCLC performs research, represents elderly clients, and assists legal services projects in bringing suits on behalf of older Americans. NSCLC receives funding from the Administration on Aging and the Legal Services Corporation to perform functions authorized by the Older Americans Act and the Legal Services Corporation Act. The Legal Services Corporation also funds three other projects either serving aged clients exclusively or with an elderly component: The Council of Elders Legal Services program in Boston,

[12] Older Americans Amendments of 1975, Public Law 94-135, approved Nov. 28, 1976.

Mass.; the California Rural Legal Assistance senior citizens program in San Francisco, Calif.; and Legal Services to the Elderly Poor in New York, N.Y.

Senator Tunney won approval of an amendment to the fiscal 1975 Labor-HEW Appropriations Act [13] to provide almost $1.2 million in model project funding under the Older Americans Act for legal representation projects. Now 11 projects are funded under section 308.

The older Americans Amendments of 1975 [14] included four provisions to make legal representation more readily available for the elderly. Legal counseling is now one of four priority services for funding under the title III State and community programs on aging. Title IV training is expanded to include lawyers and paraprofessionals to (a) provide legal counseling or (b) monitor programs for older Americans. Training is also authorized to identify legal problems affecting the elderly and to develop solutions for their needs. Legal and other counseling services to older persons is included within the title III definition of social services. And, the title IX community service employment definition now applies to legal and other counseling services. Nearly 100 legal services programs are funded under title III of the Older Americans Act, in large part because of the provisions included in the Older Americans Amendments of 1975.

However, many older Americans still "slip between the cracks" when a legal problem arises, despite the encouraging developments during the last 5 years. AoA and the Legal Services Corporation have initiated several constructive actions to strengthen legal representation for the elderly. And these activities must be continued and expanded if older Americans are to have equal access to the law as other age groups.

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[13] Public Law 93–517, approved Dec. 7, 1974.
[14] Public Law 94–135, approved Nov. 28, 1975.

MINORITY VIEWS OF MESSRS. DOMENICI, BROOKE, AND PERCY

Introduction

America's policies in aging should have the goal, as emphasized repeatedly in this committee's previous minority views, of making it possible for older Americans to enjoy satisfying lives with honor, dignity, and independence.

Elements inherent in this broad purpose include:

(1) Maximum freedom of choice in opportunities for personally rewarding activity—in work or leisure.

(2) Ready availability of facilities and services—in health care, transportation, housing, nutrition, education, and recreation—necessary to comfort, and to full participation in society.

(3) Incomes adequate to provide decent standards of living.

Creation of a social and economic climate in which these essentials of first-class citizenship may become a reality for all older Americans depends on changes in attitudes as well as effective action by all segments of society. This should include government, but the responsibility cannot be that of government alone.

Since many aspects and dimensions of current challenges in aging, none of which we regard as partisan, are detailed elsewhere in this report, we are limiting this statement to two extremely important matters within the committee's purview: (1) The continuing scandal in medical programs which serve the elderly, and (2) income maintenance in a period of sharply rising living costs.

Continuing Scandals in Health Care

Scandalous conditions uncovered in the committee's field investigations and hearings on fraud and abuse in medicare and medicaid continue to be a major problem affecting many older Americans, especially those least able to help themselves. The revelations constitute a national disgrace. It demands attention without delay.

The most recent series of inquiries began with a Subcommittee on Long-Term Care review, several years ago, of conditions in nursing homes. This revealed serious instances of physical and mental abuse of patients and fraudulent financial manipulations by operators of such institutions which bilked the taxpayer of millions of dollars each year.

Subsequently the investigation directed attention at equally flagrant abuses in other kinds of institutions and in health services outside of institutions.

It became evident that the scandalous conditions touched all kinds of health care providers (clinics, pharmacies, laboratories, hospitals, etc.), government agencies, and financial establishments (such

as factoring companies) which offer cash to physicians and others, less a substantial "collection service" percentage, for outstanding medicare and medicaid accounts receivable.

Since developments in this continuing inquiry are discussed fully in chapter II of this report and in previous documents issued by the Committee on Aging, it is unnecessary here to repeat details of either the dollar fraud, the human abuse, or the examples of malpractice discovered.

Even if the most serious conditions which have come to our attention are to be found in only some of the States, with others doing a good job of policing programs—and even if most health care practitioners and providers do provide good, honest service—the evil which does exist is too great to be ignored.

We believe its imperative that every step possible be taken now to stop current abuses and assure that they will not occur again in the future.

The problem of fraud and abuse in tax-supported medical service programs has existed too long in one form or another. This is indicated by Committee on Aging hearings going back into the early sixties. It is time for action—through legislation, executive orders, aroused citizen volunteers and every other practical means—to bring an intolerable situation under control.

At the congressional level, it appears necessary to adopt new legislation which will address the problem. A beginning could be enactment of new safeguards against fraud and abuse in federally supported programs along the lines of S. 143, medicare-medicaid antifraud and abuse amendments. This bill now before the Committee on Finance was introduced by Senator Herman E. Talmadge and has received extensive bipartisan support.

Free Choice and Income Adequacy

Needs of the 23 million Americans over 65, like those of their fellow younger citizens, vary widely by reason of individual circumstances and desires. As is true of the young and middle-aged, older persons have psychological, social, and spiritual wants as well as economic wants, which they believe society should recognize as legitimate. The economic needs, however, are ones which can be, and most clearly are, influenced by actions of the Federal Government.

Individual freedom of choice necessary to proper gratification of mental, social, or physical wants depends, in large measure, on income adequacy. This is so whether incomes are obtained from past or current personal production, from governmental income transfer systems, or from other sources. It is equally true that, unless older Americans are to be made virtual wards of the state, freedom of choice in how income adequacy is achieved also becomes important.

Creation and preservation of full opportunities for older Americans to enjoy incomes adequate to their needs, as they themselves see such needs, is a responsibility of society as a whole, and not of government alone. As has been discussed at some length in previous minority reports of this committee, attainment of full income opportunity calls for both individual and group initiatives. It imposes serious obliga-

tions on labor, business, nongovernmental social institutions, and all other elements in both the public and private sectors of the Nation. *The Federal role in the economic well-being of older Americans, however, is massive. It is obviously one of the most important areas in which Congress has major responsibilities.*

The impact of the Federal Government on the ability of older Americans to obtain and maintain decent incomes is to be found in many facets of American life. Most evident are the effects of income transfer arrangements such as are implemented in the social security, railroad retirement, and Federal employee retirement systems. Taxes, direct and indirect, and special tax concessions are important. Important also are steps to protect retirees from the consequences of rising living costs—both efforts to hold down inflation and to provide adequate relief from the problems it creates.

Income Adequacy and Inflation

As repeatedly stated by older persons in testimony before this committee, some of the most serious problems they have faced in maintaining economic independence have been those resulting from the inflationary spiral which has reduced their ability to buy the goods and services they need.

Because rising costs are often reflected most in expenses that cannot be avoided, such as food, heating fuel, rents, property taxes and other necessities, the effects of inflation have been most serious for those persons and families with the lowest incomes. For those more fortunate people who were able during their younger years to save enough for what they reasonably thought would be needed in retirement, many have seen their economic cushion dwindle and disappear.

Despite rising average incomes among older persons—in part due to automatic cost-of-living adjustments in social security first urged in minority views, Special Committee on Aging report, "Developments in Aging, 1965," and enacted in 1972—the problem remains serious.

There is need for a new look at the way the social security adjustments based on living costs are determined, and the frequency with which they take effect. The Consumer Price Index may provide an appropriate benchmark for other purposes, but it has not truly reflected the way in which inflation affects the cost of living for older Americans. Every major organization of older persons which has appeared before this committee has urged that in making future adjustments, a special index be developed for the elderly as a replacement for the C.P.I., and that such adjustments be made more often than once a year. We believe that prompt and serious consideration should be given to such changes.

Even if the income maintenance programs in which the Federal Government is involved—social security, railroad retirement, civil service retirement, veterans pensions, military retirement and supplemental security income (SSI)—were all made fully inflation-proof, however, the problems created for older persons and others on fixed incomes by rising costs of living would not disappear. Essential as these programs are, it is important that every effort be made to pre-

serve the value of other savings which retirees have worked for and accumulated to make their later years ones which they may enjoy with independence and comfort. It therefore remains important that efforts be continued to reduce the impact of inflation.

The 2 years just ended have seen substantial progress in cutting the inflation rate. In December 1974, the annual rate of inflation as measured by the Consumer Price Index was 12.2 percent; in December 1975, the rate had fallen to 7.08 percent, and in December 1976, it had been further reduced to 4.8 percent—a total reduction of 60 percent.

Gratifying as this shift from an accelerating to a decelerating rate of inflation has been, the Nation still has a long way to go in this crucial battle. Efforts to cut the inflation rate further must be pressed forward vigorously.

In assessing recent progress against inflation, it should be understood that the level of prices has not decreased. Except in severe depressions, it rarely does. Our objective today must be to continue the downward trend in the inflation rate until we come as close as is practical to the goal of price stability.

As in the past, it is reasonable to expect that, from time to time, there will be conditions or events over which our Government can exercise little or no control which will lead to an increase in our cost-of-living. Extremely harsh winters, floods, droughts, crop failures at home and abroad, and the rising world-wide demand for U.S. agricultural products can all impact adversely on the U.S. inflation rate.

We have also learned how serious can be the effect of arbitrary foreign actions, such as the late 1973 quadrupling in the price of foreign oil and subjection of this Nation to subsequent increases. Clearly new efforts must be made to give the United States a higher level of energy self-sufficiency.

Whatever may be accepted as the primary and secondary causes of inflation, national policy should aim at bringing it under control. It is important for all citizens, but it is of most crucial importance to the elderly.

Income Adequacy and Rising Energy Costs

Serious as over-all inflation is for older Americans, *one recent element in rising living costs has created especially severe difficulties for many—the extremely rapid and sharp increases in energy prices.*

Higher costs of all fuels—natural gas, bottled gas, fuel oil, gasoline, electricity, and even coal—have contributed substantially to the total inflationary spiral, but this is only part of the picture.

For millions of the elderly, the most serious current money problem is the price of energy they use directly in heating and lighting their homes and in cooking their meals. For many the problem has reached crisis proportions.

Repeated examples have come to our attention of older persons who find their bills for light, heat, and cooking amounting to 25 percent, 50 percent, or even over 100 percent of their rent or costs of home-ownership.

When such aggravated costs hit anyone, they are serious, but when they strike the old, they can create intolerable hardship, suffering, illness, and even premature death. They become doubly harsh because older persons lack the opportunities available to the young to increase

their income through higher earnings, and because there is rarely a financial "cushion" in their budgets which can absorb the added expense.

Too often the older individual or couple is faced with a choice of eating less, of sitting in the dark, of living in an underheated dwelling, of deferring purchase of needed clothing, or of giving up other necessities—all because of the unexpectedly high bills they must pay for energy alone.

Unquestionably many older persons who made what they felt was adequate financial preparation for their retirement years are now being forced to go to public assistance for survival. Still others are suffering in silence, at a time when they are most vulnerable.

Testimony has been heard that older persons risk their health if their homes are kept at low temperatures which might be adequate and safe for the middle-aged and young. No evidence is needed to underscore the importance of adequate nutritious food for the elderly. To such obviously critical elements of life as these, must be added the impairment of the older persons ability to enjoy minimal social activities when so much money goes to costs of fuel which they use directly or indirectly in their daily lives.

The fuel/energy crisis facing older Americans was serious 2½ years ago when the Special Committee on Aging first held hearings on the subject. Despite various efforts to reduce the problem, including some programs for home winterization and some efforts aimed at special electric utility rate adjustments, the difficulties facing the elderly from rising costs are more serious today. Prospects of further energy price increases and the long-range expectations of fossil fuel shortages in the United States indicate the problem may become even worse in the future.

We believe that highest priority should be assigned to the fuel and energy problem as it affects older Americans. How it can best be solved is a question for which we make no claim to a ready or simple answer. We realize that the problem's complexity will require a high level of imaginative thought and action. We hope that the ingenuity of America will be capable of coming up with answers that work.

We do know that broad energy conservation programs, important as they are to the Nation as a whole, are only part of the answer. For retirees the most critical problem is: *How can the bills be paid? We believe that the creative effort to meet this crisis of money, health, and well-being among older Americans must begin at once.*

Income Adequacy and New Data on Poverty

Elimination and prevention of poverty in the United States has been widely accepted as a national goal for many years. Its strong endorsement by both major political parties and the numerous public and private initiatives undertaken at local, State, and Federal levels demonstrate the universality of our commitment to this objective.

There may be questions as to how poverty should be defined, and to how it may best be attacked while preserving and strengthening individual dignity, but no one challenges the importance of continuing to give high priority to solving the problem.

The extent of our national concern is reflected in the wide range of programs which have been created in recent years to assist individuals at all ages. Many of the programs of special importance to older Americans are discussed elsewhere in this report.

As members of the Special Committee on Aging, we are pleased at the willingness of Congress to assign high priority to the needs of the elderly. In addition to social services, health care, housing, and nutrition programs, this priority is reflected in major improvements in the social security benefit structure during the last 10 years, and the creation of the national supplemental security income program (SSI).

Establishment of SSI was a source of special satisfaction to us. This Federal program to guarantee that no person past 65 (or persons who are totally disabled or blind) need fall below a specified income level, was enacted in 1972. Imperfect as it still is, it represented a step toward the goal envisioned by minority members of this committee in 1970 when they endorsed the concept in the late Senator Winston L. Prouty's older Americans income assurance proposal—the forerunner of SSI.

All of the programs aimed at reducing elderly poverty, including SSI, need improvement. As the Congress evaluates proposals for such improvements, however, its obligation to the taxpayers requires that we have accurate intelligence regarding progress already made. Needed also is clear evidence of where the greatest unmet needs are.

In view of this, we believe it is appropriate to call attention to a January 13, 1977, publication by the Congressional Budget Office: "Poverty Status of Families Under Alternative Definitions of Income," Background Paper No. 17.

The study on which the report is based was made at the request of then Senator Walter F. Mondale, with endorsement by Senators Edmund S. Muskie and Henry Bellmon.

The Congressional Budget Office publication said, in part:

> During the past decade, public expenditures for social welfare programs have grown four-fold—from $77.2 billion in 1965 to $286.5 billion in 1975. At the same time, according to official poverty statistics, the percentage of families in poverty has declined by only about 30 percent. An apparent paradox, this situation has led some observers to question the efficacy of the current system of public transfers. This dilemma is the result of two factors: the types of programs that account for most of the recent growth; and the inadequacies of the measures used to estimate families in poverty.
>
> The income concept used to measure poverty in the official statistics is that of the Bureau of the Census. It is basically money income before paying taxes. On this basis, Census estimated that, in calendar year 1975, 13.8 percent of families (including single-person families) were poor. However, if in-kind income is included, taxes are taken out, and the Census data base is adjusted for underreporting of incomes, a very different picture emerges. All of these calculations were made with a statistical model using family survey data. For a number of the transfer programs in the in-kind and cash assistance areas, benefits were estimated and attributed

to families according to specific program rules and general characteristics of the recipient populations. Taxes and transfer program benefits were calculated after family incomes had been adjusted for underreporting and nonreporting.

Before taxes and transfers, more than one out of every two families headed by an aged person (65 or over) is in poverty. After taxes and transfers, poverty has been virtually eliminated; only 4 percent remain poor.

The current transfer system benefits families headed by an aged person (65 or over) more than families headed by a younger person. About 16 million families (20 percent of all families) have a head who is 65 or over; more than one out of every two of these families is in poverty before taxes and transfers (table 6). For the rest of the families, the pretax/pre-transfer poverty is less than 18 percent. After taxes and transfers (including in-kind), however, poverty among the aged is virtually eliminated; only about 4 percent remain poor. Social insurance, which is dominated by social security, lifts about 70 percent of the aged poor out of poverty. As expected, the impact of social insurance on those under 65 is modest by comparison: 2[illegible] percent are moved out of poverty by the receipt of social insurance. The inclusion of cash assistance and in-kind transfers—in-kind being more important for the aged, especially food stamps, medicare, and medicaid—accounts for the rest of the dramatic poverty reduction among the aged.

TABLE 6.—FAMILIES BY AGE BELOW THE POVERTY LEVEL UNDER ALTERNATIVE INCOME DEFINITIONS: FISCAL YEAR 1976

Families in poverty	Pretax/ pretransfer income	Pretax/ post-social-insurance income	Pretax/ post-money-transfer income	Pretax/ post-in-kind transfer income	Posttax/ post-total transfer income
A. Under 65:					
Number (thousands)	10,940	8,202	6,965	4,691	4,790
Percent of under 65	17.3	13.0	11.0	7.3	7.6
B. 65 and over:					
Number (thousands)	9,297	2,977	2,107	646	654
Percent of 65 and over	57.7	18.5	13.1	4.0	4.1

Questions raised by the report are too important to be ignored. Unfortunately the "Analysis of Current Income Maintenance Programs and Budget Alternatives, Fiscal Years, 1976, 1978, and 1982: Technical Documentation and Basic Output," which describes the technical procedures used in its preparation, had not been published when these minority views were prepared. This document by Mathematica Policy Research, Washington, D.C., is expected to be available shortly. It will deserve careful attention.

Whether one chooses to accept the census reports' estimates of poverty or the revised estimates in the Congressional Budget Office report, no one would contend that poverty has disappeared among older Americans. Wherever it exists, it is a serious problem which should be met.

We look forward with interest to how fully the forthcoming additional details on the CBO's report will throw light on a number of

questions pertinent to effective progress in further elimination of poverty among the elderly. Examples of such questions are the following:

How effectively is the admittedly serious poverty problem among minority groups—blacks, Asian-Americans, Indians, and Spanish-Americans—being met?

To what extent are programs to end poverty failing among other groups, such as women, extremely frail elderly persons, etc?

How serious are the geographic differences and urban-rural differences in the effectiveness of programs in meeting economic problems of the elderly?

Perhaps even more immediately pertinent will be questions as to the validity of assumptions about the dollar value of in-kind assistance, such as under medicaid, which form a basis for the Congressional Budget Office report.

In any event, the study requested by Messrs. Mondale, Muskie, and Bellmon should receive most careful attention by every Member of the Congress, and *may well provide the basis for a much more comprehensive reappraisal of the Nation's antipoverty efforts.*

Income Adequacy and OASDI Financial Problems

The largest single source of income for older Americans by all odds is the social security system, which paid out approximately $55 billion in retirement and related benefits during the 1976 fiscal year. It affects almost every American, young or old, either as a taxpayer or a beneficiary.

Because of its extreme importance as the cornerstone of America's retirement income system, we believe it is imperative that at no time should social security's financial integrity become suspect. When questions rise about its ability to pay out promised benefits to either current beneficiaries or future beneficiaries, we believe corrective action should be taken as promptly as possible.

For almost 2 years, during which the level of reserves in the trust funds have fallen because outgo has exceeded income, we have called for action by Congress to correct the near-term and long-range financial problems of OASDI (old-age, survivors, and disability insurance).

We reiterate now our conviction that a high legislative priority by Congress on behalf of older Americans should be to correct the adverse receipts-benefits ratio which exists, and to shore up the trust fund reserves while they are still sizable.

Reassurances should be given now to retirees that this essential cash program will continue to provide payments to them, and to younger Americans when they reach retirement age.

The seriousness of the OASDI financing problems has been discussed widely in the press, it has been a concern of the social security trust fund trustees, and it has been recognized in Presidential messages and proposals to Congress.

It is a grievous and unwarranted error to charge, as some have done, that public expression of concern about OASDI's financial difficulties is an attack on the system. On the contrary, a strong commitment to tackle such problems head-on and without delay is a genuine demon-

stration of concern for the people served by social security and the importance of keeping it effective and viable.

No one is more aware of this than informed older Americans to whom social security is so vital. They are concerned not only for themselves but for retirees who will follow them in years to come. They understand that failure to respond promptly to the needs of the system is a disservice to the principle that social security must remain strong as a base for retirement income in America.

Questions in the minds of the people about the social security cash benefits program are the same today as those we raised last year:

—How can the financial integrity of OASDI be assured?

—What changes in methods of financing and/or benefit level should be considered?

—More money is needed; where will it come from?

—Will the workers, whose taxes provide current and future benefits, be willing to accept additional increases in payroll deductions big enough to meet OASDI's financial deficits?

—Should general revenues be used to meet shortages in the trust funds? If so, how much money should be taken from general treasury for this purpose? What effect would this have on income taxes imposed on both the young and the old?

—Are there other alternatives which could meet the short-term and long-term dimensions of the OASDI financial crisis?

—How do answers to these and similar questions interrelate with other legislative proposals—such as those for national health insurance?

We cannot afford, as a Nation, to approach these questions on a haphazard or piecemeal basis. OASDI is too important to the American people to be given casual treatment.

Currently more money is being paid out in OASDI benefits than is being received in social security taxes. During 1976, expenditures exceeded income by $3.2 billion.

If no corrective action is taken, there is a strong probability that deficits will continue to grow in future years, even with growing employment, thus compounding a problem which has already reached unacceptable dimensions. Under present financing arrangements the OASDI trust funds will continue to pay out more than they take in from now on until they are exhausted during the next decade.

One of the changes on which there appears to be little or no disagreement and which was discussed in previous reports of this committee, is the "decoupling" of OASDI cost-of-living benefit increases for those already retired and prospective benefit levels for those still in the work force. It may be assumed that such legislation would follow the recommendation of the 1974–75 Advisory Council on Social Security.

The Council recommended retention of the current cost-of-living adjustment for retirees, a position with which we strongly concur, but it called for elimination of this procedure as applied to the benefit formula used for those still in the work force, limiting the initial benefit formula increases to an index based on average increases in wages.

We are informed that adoption of this proposal could eliminate current OASDI deficit prospects by as much as 50 percent. This elimination of "doubled" increases for those still in the work force would be fair to all participants in the system.

Serious attention will also have to be given to various alternative financing mechanisms to correct the other half of the short-term deficit problem.

Despite the seriousness of the short range OASDI deficit problem, long-term projections of the system's operation show even greater problems ahead. How large the dollar shortages in OASDI will be depends on the relative accuracy of differing assumptions made by various experts. The general range of estimates, however, indicates that unless corrective action is taken, the deficit in terms of present dollars will be from $1 trillion to more than $2 trillion over the next 75 years.

These sizable deficits predicted by experts for OASDI during the next 50 to 75 years and beyond, unless changes are made, are primarily due to new predictions regarding three major factors:

(1) Inflation and wage level expectations;

(2) Anticipated continued early retirement trends; and

(3) Predictions that the percentage of the elderly in the population will rise substantially, due to low birth rates which will result in reduced total population growth.

We share the view that Congress will meet its responsibility to see that obligated payments of social security benefits are made. We do not share the view that there is a lot of time for developing an appropriate course of action.

Income Adequacy and Employment/Retirement Policy Changes

Outmoded retirement policies and job discrimination, based on erroneous concepts of aging unsuited to the latter part of the 20th century, often severely restrict older Americans in their efforts to remain independent and to enjoy self-rewarding lives.

Most obvious as a result of such interference with the individual right to employment is the way such policies can and do limit opportunities for many older men and women to achieve adequate income, or necessary income supplements, through their own efforts.

It should be recognized, however, that the case against arbitrary retirement and employment policies based on rigid artificial age standards goes far beyond the economic arguments. Gerontologists and medical authorities have long pointed to the social, psychological, and physical damage which may be suffered by many older persons forced into idleness against their wills. Testimony by retirees themselves has confirmed the validity of such observations.

Too often public and private retirement income plans—highly commendable and valuable in themselves—are being used as an excuse to force older Americans out of the work force without justification.

It is appropriate to note in this regard that, prior to existence of such plans, compulsory retirement rules based on age hardly existed in the United States. Rigid rules, such as are now common, largely developed during the first half of this century. This is a curious phenomenon in light of the fact that during the same period there has been so much progress in lengthening life and in expanding the ability of older persons for participation in all kinds of activities. The latter is reflected in greater productive capacities and rising social and economic appetites common to a heightened zest for living.

Even if there were no evidence of personal injury due to denial of work opportunities, it is contrary to the principles of individual liberty

on which this Nation is based to artificially relegate millions of persons to a second-class citizenship status in such an important area as employment. Every able, mature individual should be permitted to make his or her own choice about work on the basis of personal need and preference.

Paralleling the question of *self-interest* for millions of persons over 65, and persons below 65 who are victims of age discrimination in obtaining employment, is the question of *national* interest. Can this Nation afford to deprive itself of the wealth available to it through the skills, wisdom, experience, and productive capacities of older persons who want to work, full time or part time, and who are now denied the right to do so solely because of their chronological age?

The question has been raised by every President during the past 25 years and has, in each instance, been answered with a strong endorsement of the belief that America needs the contributions older persons can make to it.

In the long run it can be argued that the combination of national interest, on the one hand, and the rights of older individuals, on the other, may well make compulsory retirement and job discrimination the most important single issue in aging which faces American society. Probabilities that there will be further increases in the average age of our population, in the number of persons past 65, in average life expectancy, and in the physical and mental well-being of older Americans, only serve to strengthen this view.

The issues of compulsory retirement and job discrimination are ones which must be faced by society as a whole, and not just government alone.

The problem's solution, as discussed at length in previous minority reports of this committee, depends on new concepts of aging and older people throughout the public and private sectors of society. Most particularly there should be a new willingness by employers to look at the questions involved and to take positive action aimed at ending age discrimination in employment and bringing changes in current rigid retirement policies.

Older Americans themselves, whether still employed, seeking work, or fully retired, have made it unmistakably clear that they resent the artificial age-based interference with their right to participation in the economic processes of society. They have pointed out correctly, as have experts on the biological aspects of aging, that the imposition of forced retirement at age 65 (or 60 or 70) has no basis in the ability of men and women to do a job.

Continuation of any such policies which impose second class citizenship on older Americans is unacceptable today and may become intolerable in the future.

As we say this, we are neither expressing opposition to voluntary retirement by individuals, which quite properly is elected by many persons, nor are we ignoring the problems faced by employers, including those related to insurance and pension plans. We recognize that the problems involved are complex and require imaginative leadership of the highest order.

We recognize, too, that the solution to this problem is largely outside of the legislative field. We would be remiss in our duty as members of the Special Committee on Aging, however, if we did not express our

serious concern about the continued failure of the private sector, in its varied fields of operation, to recognize the seriousness of the problem.

It may be that part-time retirement may be an answer for both employer and employee in the future. Even as many older persons who have retired want to accept part-time jobs rather than those on a full-time basis, so it may be the future should see development of similar accommodations within the framework of jobs long held. Whatever may be the precise formula, it does appear necessary in both human and economic terms, to bring a new degree of flexibility into the labor market. This should apply both to retirement rules and hiring practices.

Essential as a new posture by employers is, there are some areas in which the need for greater flexibility in retirement practices and employment policies can be helped through congressional action.

One of these would be legislation to extend to persons over 65 the protection now afforded by the Age Discrimination in Employment Act to persons below that age, such as proposed in Senator Domenici's bill, S. 481. A second most important area for action would be changes in public programs, such as social security, whose rules currently discourage older persons interested in full-time or part-time employment during the later years.

The latter would include major liberalization or total elimination of the earnings test as it affects persons receiving social security retirement benefits and adequate compensation through benefit increments to persons who defer their retirement until ages after 65.

Both of these Social Security Act changes have been urged in previous minority reports of this committee. The flexibility they would bring to the program would be of immeasurable value to older Americans in permitting them to tailor its benefits to their own needs.

There is reason to believe that many who are now totally out of the work force would like to take jobs—full time or part time—who do not do so because of the double taxation the social security earnings test imposes on them. They just feel they cannot afford to take a job, even though they would enjoy the work and need the money. They do not see why they should work and receive so little in return.

It is impossible to estimate accurately how many productive workers would be added to the labor force, contributing to the Nation's wealth and their own satisfaction, if the test were changed. In our judgment, however, based on testimony by retirees, the number would be considerably larger than usually appears in Government estimates which have been offered in the past.

A number of bills aimed at expanding income opportunities for older Americans who want to work have been introduced during the current 95th Congress. Among those introduced or cosponsored by Republican members of the Committee on Aging are the following:

S. 146—To eliminate the social security earnings test penalties for beneficiaries age 65 and over.

S. 585—To increase from $3,000 to $5,220 the amount a social security beneficiary may earn before deductions are made from benefits due to excess earnings.

S. 615—To provide that for individuals who defer retirement until after age 65, social security benefits shall be increased 6⅔

percent for each year (until age 72) that such retirement is delayed.

We strongly recommend serious consideration of these proposals by the Senate committees with legislative jurisdiction over them. To the extent necessary under financing procedures instituted during the 94th Congress, we also urge the Senate Budget Committee to include these proposals in its deliberations.

As we make these recommendations, we do so with full knowledge that they are but steps toward a changed Federal Government posture in keeping with today's realities in aging. We re-emphasize, too, our recognition of the fact that satisfactory response to the challenges in aging during the third century of this Republic will require positive private and public initiatives at every level of American society.

Above all else in the field of aging, there is need for development of new attitudes toward aging and older persons—attitudes which recognize that the 19th century stereotypes of older persons are not valid today; attitudes which recognize that older Americans have a zest for living, a level of appetites, and the right to their full satisfaction comparable to that of their younger counterparts; attitudes which fully recognize the rights of older persons to freedom of choice as first-class American citizens.

PETE V. DOMENICI,
EDWARD W. BROOKE,
CHARLES H. PERCY.

INDEX

Hearings and reports published by this committee are indexed by the following key:

REPORTS

"Developments in Aging: 1976," page numbers are *italic*.

RCV.—"Recession's Continuing Victim: The Older Worker," a working paper prepared for use by the Special Committee on Aging, July 1976.

FAP.—"Fraud and Abuse Among Practitioners Participating in the Medicaid Program," a staff report prepared for the Subcommittee on Long-Term Care of the Special Committee on Aging, August 1976.

ADF.—"Adult Day Facilities for Treatment, Health Care, and Related Services," a working paper prepared for use by the Special Committee on Aging, September 1976.

TSS.—"Termination of Social Security Coverage: The impact on State and Local Government Employees," a working paper prepared by the Special Committee on Aging, September 1976.

AAL.—"Action on Aging Legislation in 94th Congress," committee print, prepared by the Special Committee on Aging, November 1976.

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HEARINGS

MMF.—"Medicare and Medicaid Frauds," Subcommittee on Long-Term Care and the Subcommittee on Health of the Elderly of the Special Committee on Aging, parts 1, 2, 3, and 4, Washington, D.C., September 26, November 13, December 5, 1975 and February 16, 1976.

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FSS.—"Future Directions in Social Security," Special Committee on Aging, part 24, Providence, R.I., January 26 and part 25, Memphis, Tenn., February 13, 1976.

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ILR.—"Improving Legal Representation for Older Americans," Special Committee on Aging, part 2, Boston, Mass., August 30, 1976.

A

A. & S. Dental Labs ..... FAP 75
Abberman, Jay, New York City ..... FAP 180
ABT Associates, Robert Spangenberg, statement ..... ILR 168
Abdellah, Dr. Faye, HEW, statement ..... NHF 44
Action Coalition of Elders, Pittsburgh, Pa., "Kane Hospital, a Place To Die," report ..... L–T 3321
Adams, Null, Memphis, Tenn., statement ..... FSS 2157
Adams, William B., New York State Senator ..... FAP 16
Administration on Aging:
  Asian Americans, efforts in behalf *142*
  Disaster assistance to elderly *175*
  Spanish-speaking elderly, efforts in behalf *141*
  Training and research efforts *149*
  Transportation, actions *93*
Adult day facilities:
  "After-care," program ..... ADF 28
  Barriers, progress *36*
  Funding *37*
"Adult Day Facilities for Treatment, Health Care, and Related Services," a report by Brahna Trager ..... ADF 1
Adult Day Health Center:
  Attendance required ..... ADF 14
  "Community Services for the Aged: The View From Eight Countries," article by Sheila B. Kammerman ..... ADF 107
  Day hospitals:
    Israel and Great Britain, report by Edith G. Robins ..... ADF 63
    United States-United Kingdom, differences ..... ADF 7, 25
  Funding sources ..... ADF 21
  General description ..... ADF 10
  Objectives ..... ADF 15
  Participants, age, physical limitations ..... ADF 18
  Physician care, problem ..... ADF 30
  Program coordination needed ..... ADF 42
  Program costs ..... ADF 21
  Recommendations for ..... ADF 22
  Senior group programs, origin, growth ..... ADF 32
  Services, described ..... ADF 12
  Transportation problems ..... ADF 40
  United Kingdom, defined, functions ..... ADF 7, 23
  United States:
    Comparison, tables ..... ADF 58
    Defined, functions ..... ADF 7, 24
  Utilization, factors affecting ..... ADF 18
Age Discrimination in Employment Act, recommendations ..... RCV 18
Agriculture, Department of, Illinois food stamp investigation ..... MMF 252, 297, 319
Ahart, Gregory J., GAO, statement ..... MMF 220
Alessi, Edward E., "Living Is for the Elderly," statment ..... ILR 201
Allen, Paul M., Michigan Department of Social Services, statements ..... MMF 9, 35
  Letter ..... MMF 214
American Association of Retired Persons, national health insurance proposal *39*
American Bar Association, retired attorneys provide assistance ..... ILR 163
American Health Care Association, statement ..... NHF 83
American Medical Association ..... FAP 194
  Judicial Council, opinions ..... FAP 67
American Motors Corp., injunction obtained *97*
American National Standards Institute, minimum standards *164*
American Nurses' Association:
  Holleran, Constance, letter ..... PHH 259
  Pfau, Mary Ann, statement ..... PHH 121
American Pharmaceutical Association *156*
  Apple, Dr. William S ..... FAP 80

NOTE: See page 223 for guide to code abbreviations.

Annunzio, Representative Frank, statement ..... NHF 105
Apple, Dr. William S., American Pharmaceutical Association ..... FAP 89
Architectural and Transportation Barriers Compliance Board, actions .. *163*
Architectural barriers *162*
Area agencies on aging:
Growth *69*
Services enumerated *71*
Title III funding levels by State, table *70*
Title IV training grants *111*
Arkansas, aging activities *179*
Asher, Robert S., letter to Senator Frank E. Moss ..... FAP 254
Asian Americans, efforts in behalf *142*
Asociacion Nacional Pro Personas Mayores *141*
Association of Health Care Facilities, Inc., the ..... FAP 69
Astin, Cathy, Elizabethton (Tenn.) Senior Citizens Center, statement .. FSS 2183
Attorneys, paralegal, cooperation cited ..... ILR 148
Avenue C Medical Center, New York City ..... FAP 26

B

Ballard, Richard, HEW Audit Agency, letter ..... PHH 272
Bardo, August J., Jr., New York State Department of Education .. FAP 68, 151
Bauer, Dr. Richard M ..... FAP 85
Baumol, Dr. Marvin ..... FAP 85
Beall, Senator J. Glenn, Jr., statement ..... NHF 10
Beame, Abraham D., mayor, New York City, letter to Senator Frank E. Moss ..... FAP 285
Beard, Anna, Providence, R.I., statement ..... FSS 2088
Beard, Representative Edward P. (Rhode Island), statement ..... FSS 2072
Beard, Representative Robin L., statement ..... FSS 2147
Bellin, Lowell E., New York City Department of Health ..... FAP 89, 177
Bennett, Dr. Ivan L., Jr., letter to Senator Frank E. Moss ..... FAP 273
Berman Medical Center, Detroit, Mich ..... FAP 29
Berger, Stephen:
New York State Department of Social Services ..... FAP 120
New York State Emergency Financial Control Board ..... FAP 117
Bergland, Robert, Secretary of Agriculture *121*
Bergman, James A., NCSC, statement ..... ILR 173, 178
Berliner, Dr. Robert, Yale University School of Medicine, quote, geriatric training *106*
Best, Richard L., National Fire Protection Association, statement ..... NHF 72
Blatt, Dr. Neal, 80 Delancy Medical Center ..... FAP 84
Blatt, Dr. Stanley David ..... FAP 85
Block, Richard, Josephine K. Lewis Center for Senior Citizens, statement ..... FSS 2150
Bloodworth, Mrs. Larn E., Covington, Tenn., statement ..... FSS 2164
Blue Cross:
Administration cost, State versus intermediaries ..... MMF 28
Home health care, Pennsylvania study ..... PHH 115
Blue Cross and Blue Shield of Michigan, statement ..... MMF 156
Blue Cross of Greater Philadelphia, Helen L. Rawlinson, statement ... PHH 115
Biaggi amendment, excerpt *95*
"Billing" defined ..... FAP 19
Boarding homes, for profit, conditions *27*
Boday, Michael, Rhode Island Gray Panthers, statement ..... FSS 2105
Boggs, Dr. Elizabeth M., "Issues in Long-Term Care for Persons Disabled Early in Life," article ..... ADF 45
Bondy, Magda, visiting nurse ..... FAP 191
Boston Bar Association, legal needs survey ..... ILR 168
Boston Commission on Affairs of the Elderly, James Frost, statement .. ILR 186

NOTE: See page 223 for guide to code abbreviations.

Boston Council of Elders:
Cantor, Patricia A., statement ILR 191
Cass, Melnea, statement ILR 151
McCusker, Richard, statement ILR 147
Wall, Gerald D., letter ILR 199
Statement ILR 171
Boston Council of Elders legal program ILR 174, 180
Boston Housing Authority, rent increase case ILR 173
Boston Legal Services, Greater, Gertrude K. Weiner, statement ILR 202
Boston Legislative Council for Older Americans, Frank J. Manning, statement ILR 153
Boston SSI Advocacy Center, Dorothy King, statement ILR 189
Brickfield, Cyril F., NRTA/AARP, letter PHH 243
Brock, Senator Bill, statements PHH 41, FSS 2145
Brooke, Senator Edward W., minority views *209*
Brown, Charles D., R. Ph., California Pharmaceutical Association, statement MMF 261
Brown, Dr. Coleman (Kolman), 80 Delancy Medical Center FAP 82, 84
Brown, Richard P., Unihealth Services Corp. statements PHH 81, 95
Letter PHH 239
Brydges, Earl FAP 16
Burke, Representative James A., statement ILR 142
Burns, Robert, statement FSS 2104
Butler, Robert, NIA, quote, train for research *103, 104, 105*
Butler, Dr. Robert, statement L–T 3458
Byrne, John, National Association of Home Health Agencies, statement PHH 146

C

Caddell, Patrick, the Cambridge Survey FSS 2093
California:
Aging activities *179*
Auditor general's report, "A Management Review of the Homemaker-Chore Services Program" PHH 177
Department of Health:
Jamison, Randy PHH 163
Medicaid frauds, findings PHH 34
Public employees' retirement system TSS 40
California Coordinated Health Care Services, Inc., Peter Gottheiner PHH 130, 137
California Pharmaceutical Association, Charles D. Brown, R. Ph., statement MMF 261
Callendar, Marie, materials selected from home health care development, problems, and potential ADF 88
Quote ADF 38
Cambridge-Somerville (Mass.) legal services program ILR 175
Cambridge Survey, Patrick Caddell FSS 2093
Canneries established for elderly FSS 2180
Cantor, Patricia A., Boston Council of Elders Legal Services program, statement ILR 191
Cardwell, Commissioner James; quote, social security fund deficit *15*
Carter, Gov. Jimmy, quotes:
Social security wage-base increase *16*
Decoupling social security *17*
Carter, President Jimmy; quote, cost-of-living adjustment *11*
Casey, Paul V., Old Colony Elderly Services, Inc., letter ILR 199
Casey, Thomas, Merrimack Valley Home Care Center, Inc., statement ILR 192
Cass, Melnea, Boston Council of Elders, statement ILR 151
Center for Policy Research, Dr. Amitai Etzioni, statements PHH 18, 20
Center for Studies of Mental Health of the Aging:
Research objectives *107*
Training and manpower *107*

NOTE: See page 223 for guide to code abbreviations.

Cermak Nursing Home:
Charles Chandler ... NHF 12
Fire, Gage-Babcock & Associates, Inc., report ... NHF 97
Chadi, Dr. Nourolleh ... FAP 85
Chandler, Charles, Cermak Nursing Home ... NHF 12
Charles Place Tenant Association, Flora Ware, statement ... FSS 2124
Chicago Better Government Association ... FAP 12, 17, 45,
Delaney, Geralyn, affidavits ... MMF 490
Hood, William ... MMF 421
Affidavits ... MMF 490
Longhini, Douglas ... MMF 425
Affidavits ... MMF 490
Storefront clinic opened ... MMF 423
Chicago Medical Laboratory, Mr. Robinson ... MMF 426
Chicago Tribune:
Articles, submitted ... MMF 110
Crawford, William, statement ... MMF 58
Gaines, William, statement ... MMF 67
Chiles, Senator Lawton (Florida), statement ... MMF 290
Chiropractors, medicaid frauds ... FAP 76
Church, Senator Frank:
Legislation introduced, Social Security Administration Act (S. 388) ... *20*
Medicare improvements suggested ... *39*
Quotes:
Concern for medicaid ... *32*
Home health care ... *35*
Medicare deductible increase ... *25*
Social security tax increase ... *15*
Special price index needed ... *9, 11*
Utility costs ... *147*
Statements ... MMF 6, FSS 2065
SSI amendments re disaster assistance ... *176*
Cianci, Mayor Vincent, Jr., Providence, R.I., statement ... FSS 2075
Cicero, Dr. Frank T., letter to Senator Frank E. Moss ... FAP 245
Claremont Laboratory, Mr. Simos ... MMF 427
Clark, Senator:
Quote, rural physician shortage ... *41*
Statement, value of social security protection ... TSS 9
Clinical laboratories:
Conditions described ... MMF 457
Equipment inadequate ... MMF 415
Fees:
Public versus private ... MFF 436, 445
Schedules antiquated ... MMF 445, 456, 465, 467
Illinois investigation, tests unauthorized ... MMF 270
Investigators, expertise required ... MMF 458
Kickbacks ... *26*
Defined ... MMF 432
Methods used ... MMF 414, 418, 426
Percentage paid ... MMF 426
Leasing arrangements ... MMF 431
Medicaid:
Billing practices ... MMF 418, 451, 464
Fees, privates versus public ... MMF 419
Frauds ... *26*
Illinois investigation ... MMF 417
IRS Code, provisions ... MMF 431
New Jersey Investigation ... MMF 449, 463
Overutilization ... MMF 79
Payments, table ... MMF 467
Subcontracting of tests ... MMF 450, 464
Organized crime involvement ... MMF 454
Pharmacies, percentage leasing ... MMF 433
Tests, overutilization ... MMF 428

NOTE: See page 223 for guide to code abbreviations.

Cobbs, William C., Sr., Pittsburgh (Pa.) Action Coalition of Elders, statement ..... L–T 3319
Codd, Michael J., New York City police, quote, senior citizen robbery 127
Cohen, Alan:
Dental Equities, Inc ..... FAP 73, 75
Narco Freedom, Inc ..... FAP 17
Cohen, Howard:
Dental Equities, Inc ..... FAP 73, 75
Narco Freedom, Inc ..... FAP 17
Cohen Optical Co., Robert Cohen ..... FAP 85
Cohen, William Randolph, statement ..... ILR 185
Cohen, Representative William S., statement ..... NHF 11
Cole, Dr. William E., Tennessee Commission on Aging, statement ..... FSS 2153
College of American Pathologists, Dr. Dennis B. Dorsey, letter ..... MMF 515
Community development block grant program 83
Comprehensive Employment and Training Act ..... PHH 28
Comptroller General (U.S.), fire safety report ..... NHF 124
Concourse Medical Group, Bronx, N.Y ..... FAP 31
Congressional Budget Office, welfare report 6
Congressional Research Service, Consultant Panel on Social Security, recommendations 16
Consumer Price Index, Consumer Price Index for the Elderly, comparison 8
Consumer protection laws 185
Corris, Harold, Pawtucket, R.I., statement ..... FSS 2119
Cosin, Dr. Lionel Z., quote ..... ALF 24
Council of State Governments, aging activities 189
Craighead, Dorothy, Providence (R.I.) Project Hope, statement ..... FSS 2082
Crawford, W. E., Gertrude Williams Senior Citizen's Club, statement ..... FSS 2171
Crawford, William, Chicago Tribune, statement ..... MMF 58
Credit, elderly, discrimination 161
Creighton, Frederick W., Rhode Island Council for Senior Citizens, statement ..... FSS 2079
Crime:
Against elderly, New York City 126
Elderly more vulnerable 124
Judicial and penal reforms proposed 128
New York City senior citizen robbery unit 127
Crime Control Act of 1976 125
Cross, Walter H., Massachusetts Association of Older Americans, Inc., letter ..... ILR 194
Curley, Mrs., Rhode Island Council of Senior Citizens, statement ..... FSS 2103
Cushman, Margaret J., Observations of Kane Hospital, memorandum ..... L–T 3444

D

Davis, Cathy, Senior Information and Referral Service, Kingsport, Tenn., statement ..... FSS 2183
Davis, Dr. Enrique, 164th Street Medical Clinic, Bronx, N.Y ..... FAP 39
"Day Hospitals in Great Britain and Israel," report by Edith G. Robins ..... ADF 63
Deckys, Dr. Evaldas, Narco Freedom, Inc ..... FAP 74
Delaney, Geralyn, Chicago Better Government Association, affidavits submitted ..... MMF 490
Del-Med Pharmacy, conditions described ..... FAP 83
Del-Med Service Co., Dr. Coleman Brown ..... FAP 84
Denis, Emile, Senior Citizens of Rhode Island Action Group, statement ..... FSS 2127
Dental Equities, Inc.:
Cohen, Alan ..... FAP 73, 75
Cohen, Howard ..... FAP 73, 75

NOTE: See page 223 for guide to code abbreviations.

Dentists:
Fee splitting, percentage leasing ... FAP 72, 151
Medicaid frauds ... FAP 76
Dickson, Anthony G., New Jersey State Commission of Investigation, letter ... MMF 516
Statement ... MMF 449
Dillard, Stanley, Covington, Tenn., statement ... FSS 2180
Dimitrion, James, Fairlawn Clinical and Sytology Laboratory ... MMF 455
Disson, Jerome, Narco Freedom, Inc. ... FAP 75
Division Medical Laboratory, William Footlick ... MMF 427
D. J. Medical Laboratory ... MMF 431, 436
Bills submitted to Illinois Department of Public Aid ... MMF 469
Dolan, Elizabeth, Warwick (R.I.) community action program, statement ... FSS 2129
Domenici, Senator Pete V., minority views ... *209*
Statements ... MMF 413, NHF 107
Donovan, J. J. Massachusetts Department of Elder Affairs, statement ... ILR 166
Dorsey, Dr. Dennis B., College of American Pathologists, letter ... MMF 515
Dotson, Odell, Memphis, Tenn., statement ... FSS 2178
Doty, David H., Bellaire, Tex., letter ... TSS 58
Doyle, Beatrice, Warwick (R.I.) community action program, statement ... FSS 2128
Drugs:
Advertising of prices ... *155*
Brand versus generic, cost ... FSS 2099
Cost prohibitive ... FSS 2164
Drugs in nursing homes, report ... *44*
Federal Trade Commission actions ... *156*
Generic substituted ... MMF 272
Generic substitution legislation ... *186*
Maximum allowable cost program ... *156*
Price advertising legislation ... *186*
Dunn, Richard Edward, Illinois Department of Law Enforcement, statement ... MMF 404
Dunne, George, Cook County (Ill.) board ... MMF 53
Duryea, Perry B., letter to Senator Frank E. Moss ... FAP 282

E

Early, Representative Joseph D., statement ... ILR 141
East Harlem Medical Center, New York City ... FAP 27, 35
East Los Angeles Action Council community bilingual homemaker training program ... PHH 27
Eckel, Emily, former Kane Hospital employee, statement ... L-T 3430
Edelman, Joel, Illinois Department of Public Aid ... MMF 234, 302, 348
Education:
Community Education Act ... *170*
Elderly, programs for ... *169*
Lifetime Learning Act ... *171*
80 Delancy Medical Center:
Conditions ... FAP 80
New York City ... FAP 29
Eisenberg, Allen J., Tioga County (N.Y.) Social Services Commission ... FAP 198
Elderly:
Adult day facilities, established ... *183*
Adult day health facilities ... ADF 1
Age Discrimination in Employment Act, recommendations ... RCV 18
Aged 65-plus, by State, statistics ... *xix*
Aging programs, funding sources ... *67, 81*
Architectural barriers ... *162*
Automobile ownership, statistics ... *xviii*

NOTE: See page 223 for guide to code abbreviations.

Elderly—Continued
Committee on Mental Health and Illness of the Elderly, established.. *108*
Community development block grant program..... *83*
Community Education Act..... *170*
Consumer Price Index, Consumer Price Index for the Elderly, comparison *8*
Consumer product safety..... *153*
Consumer protection laws..... *185*
Credit discrimination..... *161*
Crime against, community concern and community action..... *130*
Crime against, more vulnerable..... *124*
Crime against, prevention efforts..... *130*
Crime preventive legislation introduced..... *125*
Disaster assistance..... *175*
Drugs:
Cost prohibitive..... FSS 2164
Generic substitution legislation..... *186*
Price advertising legislation..... *186*
Educational attainment..... *xvii*
Educational programs..... *169*
Employment:
Among minorities..... *137*
Committee findings and recommendations..... *92*
Legislation *89, 91*
Statistics ..... *xvii*
U.S., by age and sex, table..... RCV 10
White House Conference recommendations..... *205*
Canneries established..... FSS 2180
Energy inflation, effect on elderly..... *147*
Food stamp outreach program needed..... FSS 2081
Gardens, budget saving..... FSS 2180
Health cost per capita, statistics..... *xv*
Health costs and problems..... *23*
Health legislation introduced..... *122*
Health, White House Conference recommendations..... *201*
Housing:
Congregate facilities..... *60*
Inadequate supply..... *53*
Problems *53*
Need cited..... FSS 2112
Rural, legislative progress..... *65*
Section 8 program..... *121*
Section 202 program..... *56, 120*
Single room occupancy problem..... *64*
Supply inadequate..... FSS 2156
Tenant management..... *63*
White House Conference recommendations..... *204*
Home health care..... ADF 36
Progress *54*
Round-the-clock-service needed..... PHH 71, 76, 89
HUD, Assistant Secretary for Housing..... *59*
Income inadequate, committee findings and recommendations..... *21*
Income, White House Conference recommendations..... *199*
Indians, health needs..... *138*
Inflation, effect on..... FSS 2078, 2087, *8, 10*
Legal representation needed..... FSS 2170
Legal services:
Boston Bar Association, needs survey taken..... ILR 168
Boston legal research and services program..... ILR 173, 178
Class action suits effective..... ILR 175
HEW funding..... ILR, 162, 180,
Need for..... *194*
Needs enumerated..... ILR 187

NOTE: See page 223 for guide to code abbreviations.

Elderly—Continued
Legal services—Continued
Nursing home ombudsman project ILR 166
OAA funds, disposition *192*
Paralegals, assistance exemplified ILR 148
Paralegals, function as ILR 148
Personnel insufficient ILR 176
Plight exemplified ILR 177, 179, 183
Problems enumerated ILR 164, 172, 179
Problems unique ILR 156, 161, 164, 172
Retired attorneys provide assistance ILR 163
Scarce, reasons *191*
Suggestions ILR 182
Suggestions to improve *195*
White House Conference recommendations *207*
Legislation affecting, 94th Congress AAL 1
Life expectancy, statistics *xvi*
Lifetime Learning Act *171*
Living arrangements, statistics *xvii*
Marital status, statistics *xvi*
Medicaid:
Fee-for-services system PHH 26
Out-of-pocket payments increase, causes *24*
Voucher system PHH 19
Medicare, deductible increase FSS 2066, 2091
Mental health, Center for Studies of Mental Health of the Aging, established *107*
Minorities:
Committee conclusions *143*
Major actions affecting *136*
White House Conference recommendations *206*
Mobility, statistics *xvii*
Multidisciplinary centers of gerontology, funded *115*
National health program advocated FSS 2090
NIA, aging research supported *102*
NRTA/AARP tax aide program ILR 162
New York City, crime against, exemplified *126*
New York City senior citizen robbery unit *127*
Nursing home:
Bed availability, discrimination ILR 168
Patient bill of rights *187*
Patients, statistics *xv*
Nutrition:
Congregate meals, statistics *75*
Funding increased *73*
Meals-on-wheels program *75*
Nutrition programs FSS 2082
Paralegal training *182*
Personal income, disposition *xv*
Physician care, problems ADF 30
Place of residence, statistics *xvii*
Plight exemplified FSS 2176
Population, U.S.:
Health status, statistics *xiv*
1776 to present, statistics *xiii*
Poverty:
By age and sex, table RCV 11
By race, tables *132, 133, 134*
Levels, methods of computing *5*
Minorities suffer more *132*
Table *4, 86*
Prepaid health plans PHH 26
Problems enumerated FSS 2076, 2155, 2162

NOTE: See page 223 for guide to code abbreviations.

83-453 O - 77 - 17

Elderly—Continued
Problems, solutions suggested ..... FSS 2162
Program coordination needed ..... ADF 42
Property tax relief program 54
Recession, effect on 85
Recession's continuing victim ..... RCV 1
Retired couple budget, table 3
Revenue sharing plan, effect ..... FSS 2091, 2094
Rural:
Committee findings and recommendations 123
Disadvantaged 122
Health services distant 121
Medicare-medicaid inaccessible 40
Needs emphasized 119
Neglected 118
Safety standards considered 153
Senior centers:
Funding 76
Participant characteristics ..... ADF 34
Senior group programs, origin, growth ..... ADF 32
Sex ratio, statistics xvi
Sheltered housing concept 183
Social security:
Automatic cost-of-living adjustment 10
Blacks underrepresented 135
Earnings limitation unfair ..... FSS 2154, 2157, 2173
Part-time employment limitation ..... FSS 2120
Special price index needed 9
State agencies on aging:
Developments 178
Health programs 182
State legislation suggested 189
Supplemental Security Income:
Benefits by race, table 135
Eligibility, many unaware 13, 194
Outreach program needed ..... FSS 2080
Tax reform, changes enumerated 166
Tax reform Act of 1976 166
Taxes:
Property tax relief program 185
Protect from overpayment, itemized deductions listed ..... OIT 1
Relief advocated ..... FSS 2106
Telephone a must, cost ..... FSS 2110
Title XX agreements, use of funds 180
Transportation:
Administration on Aging actions 93
Barriers 165
Equal right to 95
Inadequate ..... FSS 2085, 2162
Local programs 99
Needs emphasized 94, 119
Problems ..... ADF 40
Unemployment:
Duration, table 87
Increase 85
Tables, by age and sex ..... RCV 2
Utility rates, effect on ..... FSS 2109, 2158, 2176
Volunteer tax consultant training 168
Voter participation, statistics xvii
Weatherization program 149, 152
Welfare, effect on 6

NOTE: See page 223 for guide to code abbreviations.

11th District Dental Society (Queens County, N.Y.), Dr. Emil Lentchner ---- FAP 15
Elizabethton (Tenn.) Senior Citizens Center, Cathy Astin, statement ---- FSS 2183
Elliott, Robert R., HUD, letter ---- NHF 60
Elowitz, Gertrude, New York Community Service Society ---- FAP 192
Employee Retirement Income Security Act ---- *171*
Reporting and disclosure ---- *173*
Employment:
Elderly:
By age and sex, table ---- RCV 10
Committee findings and recommendations ---- *92*
Legislation ---- *89, 91*
Minorities ---- *137*
White House Conference recommendations ---- *205*
Energy (see also Utilities):
Fuel adjustment clauses, automatic ---- *151*
Inflation, effect on elderly ---- *147*
Oil, home heating, decontrolled ---- *151*
Weatherization program ---- *149, 152*
Energy Conservation and Production Act, provisions ---- *149*
Equal Credit Opportunity Act Amendments of 1976, enacted ---- *161*
Erlich, Thomas, Legal Services Corp., quote, too few lawyers ---- *195*
Erwin (Tenn.) Senior Citizens Center, Evelyn Stultz, statement ---- FSS 2187
Etzioni, Dr. Amitai, Center for Policy Research, statements ---- PHH 18, 20
Position paper ---- PHH 260
Every 10th American ---- *xiii*
Eyeglasses, legislation passed ---- *186*

F

Factoring firms, defined ---- FAP 15
Fairlawn Clinical and Sytology Laboratory, James Dimitrion ---- MMF 455
Family Health Professionals Office, New York City ---- FAP 27
Farmers Home Administration (FmHA), home loans ---- *120*
Farnsworth and Associates ---- MMF 43
Federal Advisory Commission on Legislation, Ralph Perrotta, statement ---- FSS 2119
Federal Disaster Assistance Administration ---- *175*
Federal Trade Commission, funerals, actions ---- *157*
Fennessey, Cecilia, Franklin Field housing project, Boston, statement ---- ILR 144
Finkbeiner, Dr. John A., letter to Senator Frank E. Moss ---- FAP 264
Fire safety:
Code compliance ---- NHF 28, 29, 36, 38
Comptroller General report ---- NHF 124
Corridors, dead end ---- NHF 4
Doors, self-closing ---- NHF 8, 68, 69
Electrical wiring ---- NHF 79
Evacuation of residents ---- NHF 16
Fire-resistant furnishings ---- NHF 39
Fire test report ---- NHF 338
Flammability standards, floor coverings ---- NHF 296
Flammability testing ---- NHF 65
Flammable furnishings ---- NHF 4
GAO report ---- NHF 5, 11
HEW training sessions ---- NHF 45
Industry involvement ---- NHF 64
Legislation, recent ---- NHF 10
Life Safety Code deficiency report ---- NHF 216
Lighting, emergency ---- NHF 80
Loan application procedures ---- NHF 49
Loan applications, waivers ---- NHF 58
Respirators, usefulness ---- NHF 20
Smoke detectors ---- NHF 25, 71

NOTE: See page 223 for guide to code abbreviations.

Fire safety—Continued
Smoke detectors, cost estimate, report ..... NHF 340
Smoke, toxic ..... NHF 8, 9, 66–69, 75, 77
Sprinklers:
Importance of ..... NHF 7, 43, 71, 77, 78
Installation ..... NHF 30, 46, 47
Loan insurance ..... NHF 31–33, 41
Staff training procedures ..... NHF 35
Standards, NFPA ..... NHF 73
First Ipswich Co., Inc., Frank C. Romano, Jr., letter ..... NHF 109
First Tennessee-Virginia Development District Area Agency on Aging, Ben Peeples, statement ..... FSS 2189
Flemming, Arthur S., HEW, statement ..... PHH 207
Food and Drug Administration, hearing aid regulations *157*
Food stamps, outreach program needed ..... FSS 2081
Footlick, William, Division Medical Laboratory ..... MMF 427
Ford, President Gerald R.:
Health proposal ..... FSS 2090, 2094,
Social security payroll tax increase *15*
Ford, Representative Harold E., statement ..... FSs 2149
Fountain report ..... FAP 200
14th Street Medical Center, New York City ..... FAP 29, 39
Franklin, Peter, HEW ..... PHH 57
Statement ..... PHH 209
Frauds, see medicaid and medicare.
Frenchik, Eileen, R.N., Kane Hospital, statement ..... L–T 3452
Friesz, Dr. Raymond H., letter to Senator Frank E. Moss ..... FAP 270
Fristachi, Joseph L., letter to Senator Frank E. Moss ..... FAP 240
Frost, James, Boston Commission on Affairs of the Elderly, statement ..... ILR 186
Fuchs, Lawrence N., Homemaker-Home Health Aide Association of New York State, letter ..... PHH 242
Funerals:
Federal Trade Commission actions *157*
NRTA/AARP position *158*

G

Gage-Babcock & Associates, Inc.:
Cermak House Nursing Home fire report ..... NHF 97
Wincrest Nursing Home fire report ..... NHF 89
Gaines, William, Chicago Tribune, statement ..... MMF 67
"Ganging" defined ..... FAP 18
Garrahy, Lt. Gov. J. Joseph (R.I.), statement ..... FSS 2074
General Accounting Office:
Abart, Gregory J., statement ..... MMF 220
Iffert, Robert E ..... NHF 27
Martin, James D., statement ..... NHF 27
Medicaid, cost of program ..... PHH 41
Illinois medicaid investigation:
Audits opposed ..... MMF 238
Charge denied ..... MMF 294, 307, 319, 328
Cooperation cited ..... MMF 294
Evidence withheld ..... MMF 238, 242, 244, 251
Evidence withheld charge denied ..... MMF 295, 319, 324
Medicaid report, findings ..... FAP 199
Nursing home fire report ..... NHF 5, 11
Pittsley, George, statement ..... MMF 220
Simon, John, contacts enumerated ..... MMF 294
Zipp, Alan ..... NHF 27
Geriatrics:
AoA training grants, disposition *109*
Committee findings and recommendations *117*
Medical schools/training programs few *105*

NOTE: See page 223 for guide to code abbreviations.

Geriatrics—Continued
Multidisciplinary center of gerontology, funded ... *115*
NIA, aging research supported ... *102*
Title IV multidisciplinary center training grants enumerated ... *116*
Title IV–B research grants, enumerated ... *112*
Gendron, Lola, Central Falls, R.I., statement ... FSS 2114
General Motors Corp ... *97*
General revenue financing:
Social security, rejected ... *17*
General revenue sharing ... *81*
General Revenue Sharing Amendments of 1976 (Public Law 94-488), provisions ... *82*
Gentry, Dr. Robert, New York City ... FAP 180
Gerard, Charles, Providence, R.I., letter ... FSS 2132
Gertrude Williams Senior Citizen's Club, W. E. Crawford, statement ... FSS 2171
Gillespie, L. O., Ripley, Tenn., statement ... FSS 2154
Goff, John, Illinois Department of Public Aid:
Credibility attacked ... MMF 292
307, 312, 324, 376
Statement ... MMF 233
Threatened ... MMF 236
244, 250, 322, 366
Threat denied ... MMF 298, 320, 349
Gordon, Jerome, Narco Freedom, Inc ... FAP 75
Gorfine, Edward W., Massachusetts Bar Association, statement ... ILR 200
Gottheiner, Peter ... FHH 150, 161
California Coordinated Health Care Services, Inc ... PHH 130, 137
Yuba County (Calif.) Visiting Home Services Association ... PHH 33, 35
Gouveneur Medical Center, New York City ... FAP 26
Graham, Henry, East Greenwich, R.I., statement ... FSS 2106
Grand Street Medical Center, Brooklyn, N.Y ... FAP 29
Greene, George, Mermaid Medical Building Realty Corp ... FAP 70
Griffith, Emlyn I., letter ... FAP 278
Grimes, Martin, National Fire Protection Association ... NHF 72
Grossman, William E., HUD, memorandum ... NHF 50
Gupta, Dr. S ... FAP 85

H

Halamandaris, Val J., associate counsel and investigator, Senate Special Committee on Aging ... FAP 31
Statement ... MMF 417
Halamandaris, William, Senate investigator ... FAP 26, 29,
Handicapped:
American National Standards Institute, minimum requirements ... *164*
Architectural barriers ... *162*
Consumer product safety ... *153*
Safety standards considered ... *153*
Transportation:
Barriers ... *165*
Equal right to ... *95*
Local programs ... *99*
Hall, Hadley D., San Francisco Home Health Services, statement ... PHH 130, 135, 150
Hawaii, aging activities ... *179*
Hawes, Catherine, Senate investigator ... FAP 29, 31,
Hawes, Gerald A., California Office of the Auditor General, statement ... PHH 23
Health care facility, surveyors, inventory of ... NHF 229
Health care, State activities ... *188*
Health costs and problems, committee findings and recommendations ... *42*
Health, Education, and Welfare, Department of:
Abdellah, Dr. Faye, statement ... NHF 44
Ballard, Richard, letter ... PHH 272

NOTE: See page 223 for guide to code abbreviations.

Health, Education, and Welfare, Department of—Continued
Committee on Mental Health and Illness of the Elderly, established.. *108*
Fire safety training sessions..... NHF 45
Flemming, Arthur S., statement..... PHH 207
Fountain report, findings..... FAP 200
Franklin, Peter..... PHH 57
Statement..... PHH 209
GAO report on Medicaid, findings..... FAP 199
Haislip, Gene..... NHF 44
Hitt, Marvin..... NHF 44
Home health care:
Proposed regulations, discussion..... PHH 24, 82, 86, 101
Proposed regulations opposed..PHH 6, 9, 18, 24, 82, 100, 108, 112, 119, 122,
Regulations, proposed changes..... PHH 48,198
Illinois welfare investigation, State cooperation cited..... MMF 296
Katz, Louis..... FAP 187
Medicaid audits, reaction to criticism..... FAP 208
Medicaid Provider Abuse Detection program, findings, recommendations..... FAP 105
Medicaid regulations clarified..... PHH 52
Medical Assistance Program, State of New York, audit, findings.. FAP 96
Medicare deductible increased..... FSS 2094, *25*
Medicare fraud investigative unit established..... *39*
Medicare regulations more stringent..... PHH 11, 15,
Morehart, Jonas..... NHF 44
Morelli, Michael..... NHF 44
Nursing home audits by State, tables..... FAP 203
Nursing homes:
Patient personal accounts, lack of regulations..... MMF 221
Patient personal accounts, requirements..... MMF 225
Office of Welfare Inspector General, establish..... MMF 30
Proposed regulations:
Abuse potential great..... PHH 36
Care quality increased..... PHH 86
Conflict of interest possible..... PHH 123
Double standard, danger of..... PHH 122
Medicaid, rules clarified..... PHH 52
Positive changes..... PHH 112
Prior notice to all..... PHH 154
Profit motive necessary?..... PHH 124
Proprietaries consulted..... PHH 134
State licensure..... PHH 159
Proprietary home health care, state licensure..... PHH 49, 68, 78, 89, 98, 113
Proprietary regulations questioned..... PHH 6, 9, 15, 18
Ryder, Peter..... PHH 56
Walsh, Robert, letter..... FSS 2134
Weikel, Dr. Keith, statement..... PHH 48
Health Insurance Benefits Advisory Council report, quote..... ADF 39
Health Maintenance Organization Act of 1976, Public Law 94-640..... *35*
Hearing aids:
Food and Drug Administration, regulations..... *157*
Legislation passed..... *186*
Heinz, Representative H. John, III, statements..... PHH 3, NHF 8
Hess, Arthur E., Social Security Administration, quote, "Our medicare experience"..... *38*
Hester, Dr. Alan, Oak Park, Ill..... MMF 43
Hilao, Dr. Jose Jaime..... FAP 46
Hill, Ms. Lessie, Senior Citizens Advocate Center described..... *197*
Hinds, Howard N., Legal Services for the Elderly, Johnson City Tenn., statement..... FSS 2184
Hipps, George, HUD..... NHF 48
Hoffman, Bruno, Providence, R.I., statements..... FSS 2089, 2127

NOTE: See page 223 for guide to code abbreviations.

Hoffman, Donald R., assistant attorney general, Kansas, statement--- MMF 255
Report submitted--- MMF 275
Holleran, Constance, American Nurses' Association, letter--- PHH 259
Holstein, Frank L., New Jersey State Commission of Investigation, statements--- MMF 449, 463,
Home health care:
Availability, physicians, patients unaware--- PHH 61
Categories explained--- PHH 116
Costs, figures misleading--- PHH 132, 139
Eligibility categories--- PHH 64, 70
Employee bonding--- PHH 154
Expansion needed--- PHH 109
HEW:
Proposed regulations--- PHH 48, 82, 86, 198
Proposed regulations opposed--- PHH 6, 9, 18, 24, 82, 100, 108, 112, 119, 122
Legislative efforts--- *35*
Medicare abuse alleged--- PHH 130, 137
Nursing home, cost comparison--- PHH 43
Pennsylvania study, cost, statistics--- PHH 115
Private versus public, cost comparison--- PHH 81, 85
Profit-nonprofit cost comparison--- PHH 143
Profit versus nonprofit, quality of care--- PHH 57
Progress limited--- *34*
Proprietaries underbid volunteers--- PHH 126
Quality control--- PHH 80
Report, "A Management Review of the Homemaker-Chore Services Program," by the auditor general of California--- PHH 177
Round-the-clock services needed--- PHH 71, 76, 89
Services now available--- PHH 62
Staff, inadequate training--- PHH 79
Visiting Nurse Service of New York: Cost per admission, table--- PHH 114
Home-Kare, Inc., Fred Keeley, statement--- PHH 158
Homemaker Chore Services, HEW audits--- PHH 272
Homemaker-Home Health Aide Association of New York State, Lawrence N. Fuchs, letter--- PHH 242
Homemaker-home health aide service:
Aides, selection of--- PHH 104
Chore service substituted--- PHH 23, 107, 272
Functions--- PHH 101
Monitoring program--- PHH 106
Reporting and accounting procedure recommended--- PHH 105
Training--- PHH 103
Homemaker training, costs--- PHH 28
Hood, William, Chicago Better Government Association--- MMF 421
Affidavits--- MMF 490
Statement--- MMF 41
Hospitals:
Medicare insurance protection--- TSS 11
Medicare redtape increases cost--- FSS 2160
H.R. 1354--- PHH 71
House Ways and Means Committee, social security actions--- *16*
Housing:
Committee findings and recommendations--- *66*
Elderly:
Congregate facilities--- *60*
Need cited--- FSS 2112
Rural, legislative progress--- *65*
Section 8 program--- *121*
Section 202 program--- *56, 120*
Single room occupancy problem--- *64*

NOTE: See page 223 for guide to code abbreviations.

Housing—Continued
Elderly—Continued
Supply inadequate ... FSS 2156, 53
Tenant management ... 63
White House Conference recommendations ... 204
Housing Act of 1976, Public Law 94-375, provisions ... 57
National Association of Housing and Redevelopment Officials, recommendations ... 60
Resident manager certification ... 62
Sheltered housing concept ... 183
State activities ... 188
Housing Act of 1976, Public Law 94-375, provisions ... 57
Housing and Urban Development, Department of:
Assistant secretary for housing for the elderly ... 59
Congregate housing facilities ... 60
Elliott, Robert R., letter ... NHF 60
Grossman, William E., memorandum ... NHF 59
Hipps, George, statement ... NHF 48
Hsiao, William, Consultant Panel on Social Security, recommendations ... 16
Hunter, Byron, Memphis, Tenn., statement ... FSS 2178
Hurwitz, Dr. Paul, Wincrest Nursing Home ... NHF 12
Hutchinson, Dr ... MMF 47
Hynes, Charles J., New York State Department of Law ... FAP 158, 31

I

Idaho, aging activities ... 178
Iffert, Robert E., GAO ... NHF 27
Illinois:
Better Government Association, factoring investigation ... MMF 41
Department of Law Enforcement, Richard Edward Dunn, statement ... MMF 404
Department of Public Aid ... MMF 42
Bills submitted by D. J. Medical Laboratory ... MMF 469
Criticism ... MMF 234
Criticism refuted ... MMF 292, 324, 349, 376
Edelman, Joel ... MMF 234
Statement ... MMF 348
Goff, John:
Credibility attacked ... MMF 292, 307, 312, 324, 376
Statement ... MMF 233
Threatened ... MMF 236, 244, 250, 322, 366
Threat charge denied ... MMF 298, 320, 349
Personnel, unqualified transferred to ... MMF 367
Positive actions taken ... MMF 292
Simon, John B., statement ... MMF 324
Slavens, Gerald ... MMF 241, 320
Trainor, James L ... MMF 235, 238
Statement ... MMF 291
Waste cited ... MMF 234, 242, 322, 370
Welfare checks withheld ... MMF 234
Explanation ... MMF 355
Factoring, causes effects ... MMF 41
Food stamp investigation ... MMF 252, 297, 319
Medicaid investigation ... MMF 417
Computer program established ... MMF 293
Factoring firms, favored ... MMF 243, 251
Favoritism denied ... MMF 301, 312, 329, 345, 359
GAO cooperation cited ... MMF 294
GAO audits opposed ... MMF 238
GAO audits opposition, charge denied ... MMF 294, 307, 319, 328
GAO, evidence withheld charged ... MMF 238, 242, 244, 251
GAO, evidence withheld charge denied ... MMF 295, 319, 325, 328

NOTE: See page 223 for guide to code abbreviations.

Illinois—Continued
Medical investigation—Continued
Goff testimony rebutted ... MMF 292, 307, 312, 324, 376
Hatch Act violation cited ... MMF 234, 240
Hatch Act violation denied ... MMF 298, 316, 320
Material sent to U.S. Attorney General by Senator Frank E. Moss ... MMF 387
Political interference charged ... MMF 234
Political interference denied ... MMF 352, 363, 374, 378
Prosecution lacking ... MMF 244, 371
Medical Payments Task Force:
Established, purpose ... MMF 292
Information shared with Government agencies ... MMF 327
Moore, Donald Page ... MMF 235, 292, 325, 376
Simon, John ... MMF 235, 249, 294, 298, 334, 347
Medicaid mills, physician involvement ... FAP 45
Springfield Better Government Association, William L. Hood, statement ... MMF 41
State Medical Society ... MMF 304
Illinois Association of Clinical Laboratories, Edmond L. Morgan, statement ... MMF 79, 129
Illinois Medical Laboratory ... MMF 436
Illinois Medical Society Advisory Committee, Dr. George Mitchell ... MMF 304
Indians, elderly, health needs ... *138*
Indian Health Care Improvement Act:
Appropriations, table ... *139*
Enacted ... *138*
Inflation:
Elderly, effect on ... FSS 2078, 2087, *8*, *10*
Fuel adjustment clauses, automatic ... *151*
Natural gas price increase ... *150*
Oil, home heating, decontrolled ... *151*
Price control advocated ... FSS 2088
Utility costs, effect on elderly ... *147*
Institutionalization:
Alternatives, voucher, system ... PHH 19, 23
Nursing homes, alternatives ... PHH 49
Inter-Med Clinic, Los Angeles ... FAP 31
Intermediaries, medicaid administration cost, comparison ... MMF 28
Internal Revenue Service:
Taxes, committee findings and recommendations ... *169*
Tax reform, changes enumerated ... *166*
Volunteer tax consultant training ... *168*
Internal Revenue Code, medicaid fraud provisions ... MMF 431
International Business Machines Corp., recommendation ... FAP 96
Israel, day hospitals in ... ADF 63

J

Jamison, Randy, California State Department of Health ... PHH 163
Johnson, Chandler W., Providence, R.I., statement ... FSS 2116
Johnson, Mrs. Frankie B., Memphis, Tenn., statement ... FSS 2179
Johnson, Thomas P., assistant U.S. attorney ... MMF 300
Josephine K. Lewis Center for Senior Citizens, Richard Block, statement ... FSS 2150

K

Kamerman, Sheila B., "Community Services for the Aged: The View from Eight Countries," article ... ADF 107
Kandel Medical Center, Los Angeles ... FAP 31
Kane hospital:
Alternatives lacking ... L–T 3429, 3440
Brochure misleading ... L–T 3503

NOTE: See page 223 for guide to code abbreviations.

Kane hospital—Continued
Butler, Dr. Robert, observations ..... L–T 3458
Cushman, Margaret J., R.N., memorandum concerning ..... L–T 3444
Drugs, administered by aides ..... L–T 3468
Eckel, Emily, former employee, statement ..... L–T 3430
Lewin, Mary, former social worker, statement ..... L–T 3424
McCormley, Father Hugh J., chaplain, statement ..... L–T 3453
Nagy, Joseph, former nurses' aide, statement ..... L–T 3434
Nursing staff inadequate ..... L–T 3430
Patients:
Care inadequate ..... L–T 3425, 3431, 3440, 3450
Extortion ..... L–T 3438
Finances obscure ..... L–T 3428
Plight described ..... L–T 3431, 3436, 3444, 3450, 3453, 3468
Pennsylvania State Department of Health inspection report ..... L–T 3471
Physicians, indifferent ..... L–T 3424
Physicians, understaffed ..... L–T 3424
Quarantine procedure ignored ..... L–T 3435
Staff inadequate ..... L–T 3452
Supplies and equipment, shortages ..... L–T 3431, 3452
Toilet facilities inadequate ..... L–T 3447
Utilization review program nonexistent ..... L–T 3443
"Kane Hospital, A Place To Die," report distributed by the Action Coalition of Elders, Pittsburgh, Pa ..... L–T 3321
"Kane Hospital Cares," brochure ..... L–T 3505
Kansas, nursing home investigation:
Findings ..... MMF 255
Staff, inadequate ..... MMF 255, 260
Katz, Louis, HEW ..... FAP 487
Kaufman, Dr. Paul S., letter to Senator Frank E. Moss ..... FAP 273
Keegan, Jim, Institute of Mental Health, statement ..... FSS 2097
Keeley, Fred, Home-Kare, Inc., statement ..... PHH 158
Kennedy-Corman bill ..... FSS 2093
Kennedy, Senator Edward, statement ..... ILR 139
Khan, Riaz, Westlawn Clinical Laboratory ..... MMF 420, 428
Kickbacks, New York nursing homes *31*
Kilbreath, J. M ..... MMF 53
King, Dorothy, Boston SSI Advocacy Center, statement ..... ILR 189
Kirkess, Mrs. William C., Memphis, Tenn., statement ..... FSS 2175
Knauer, Virginia H., White House Office of Consumer Affairs *158*
Koch, Representative Edward I., statements ..... PHH 9, 14
Kodick, John Alexander, Los Angeles Homemaker Training program, statement ..... PHH 27
Koff, Theodore, quotes:
Day care, a part of service ..... ADF 42
Role of day care *38*
Kurtz, Dr. Morton, Queens County (N.Y.) Medical Society ..... FAP 66

L

Laboratories, medicaid frauds ..... MMF 16
Labor, Department of, labor manpower programs, table *88*
Labor force, participation rates, tables ..... RCV 6, 15
Lane, Josie E., Memphis, Tenn., statement ..... FSS 2176
Lando, Dr. Lewis A ..... FAP 85
LaPena, Nemie, Northside Clinical Laboratory ..... MMF 427
Lara-Valle, Dr. Julio ..... FAP 46, MMF 431
Laurence, Stuart, New York City health department investigator ..... FAP 178
LaVor, Judy, materials selected from Home Health Care Development, problems, and potential ..... ADF 88
Law Enforcement Assistance Administration, crime statistics released *124*
Leach, Elizabeth, Memphis, Tenn., statement ..... FSS 2170
Legal services:
Committee findings and recommendations *198*

NOTE: See page 223 for guide to code abbreviations.

Legal services—Continued
Elderly:
Inadequate ---- FSS 2170, *191*, *194*
Needs enumerated ---- ILR 187
OAA funds, disposition ---- *192*
Problems unique ---- ILR 156, 161, 164, 172
Suggestions to improve ---- *195*
White House Conference recommendations ---- *207*
Funds, alternate sources ---- *195*
HEW funding ---- ILR 162, 180
Older Americans Act, title III funds, use of ---- *182*
Paralegals:
Elderly, assistance exemplified ---- ILR 148
Elderly function as ---- ILR 148
Elderly, training of ---- *182*
Legal Services Corporation:
Funded ---- *192*
Erlich, Thomas ---- *195*
Legal Services for the Elderly, Johnson City, Tenn., Howard N. Hinds, statement ---- FSS 2184
Legislation, elderly, 94th Congress ---- AAL 1
Lentchner, Dr. Emil:
11th District Dental Society (Queens County, N.Y.) ---- FAP 15
Letter to Senator Frank E. Moss ---- FAP 271
Lester, Eileen, quote ---- ADF 14
Levenson, Lewis M., Somerville-Cambridge (Mass.) Home Care Corp., statement ---- ILR 191
Levitt, Arthur, letters to Senator Frank E. Moss ---- FAP 235
Lewin, Mary, Pittsburgh (Pa.) Free Clinic, statement ---- L–T 3424
Lewis, Janet, Warwick, R.I., statement ---- FSS 2097
L'Heurault, Barbara, Pawtucket, R.I., statement ---- FSS 2114
Libow, Dr. Leslie, quote, need for geriatric medicine ---- *107*
Life Safety Code:
Deficiency report ---- NHF 216
Fire safety standards ---- NHF 73
Lindsay, John V., former mayor, New York City, letter to Senator Frank E. Moss ---- FAP 283
Lirode, Service, Inc., Alan and Howard Cohen ---- FAP 75
"Living is For the Elderly," Edward E. Alessi, statement ---- ILR 201
Longhini, Douglas, Chicago Better Government Association ---- MMF 425
Affidavits ---- MMF 490
Long-term care facilities, expansion, administration efforts ---- *48*
Lorenz, Dr. John ---- FAP 85
Louisiana, Parochial Employees' Retirement System of ---- TSS 34
Lugarina, Francisco, Narco Freedom, Inc ---- FAP 75

M

McCabe, John C., Blue Cross and Blue Shield of Michigan, letter and statement submitted ---- MMF 156
McCarthy, Bennett J., Blue Cross and Blue Shield of Michigan, letter and statement submitted ---- MMF 156
McCormack, Owen, Medical Facilities, Inc., (Bronx, N.Y.) ---- FAP 72
McCormley, Father Hugh J., chaplain, Kane hospital, statement ---- L–T 3453
McCusker, Richard, Boston Council of Elders, statement ---- ILR 147
McDew, Pvt. Darrell R., Senate investigator ---- FAP 20, 26
McGovern, Senator George, quote, meals on wheels program ---- *75*
McGovern, Dr. John, 80 Delancy Medical Center ---- FAP 83
McKiernan, Madeline, Providence, R.I., statement ---- FSS 2095
McKinney, Ernest, Johnson City, Tenn., statement ---- FSS 2186
McLaughlin, Dr. Mary C., letter to Senator Frank E. Moss ---- FAP 286
McLean, James H., Allegheny County (Pa.) law Department statement ---- L–T 3533

NOTE: See page 223 for guide to code abbreviations.

Madio, Daniel, Merrimack Valley Home Care Center, statement ..... ILR 202
Maine, legal aid program ..... ILR 180
Malone, David ..... FSS 2123
Manning, Frank J., Boston Legislative Council for Older Americans, statement ..... ILR 153
Marinelli, Robert, attorney ..... FAP 16
Marlin, David, Legal Research and Services for the Elderly, quote, legal services needed *194*
Martin, James D., GAO, statement ..... NHF 27
Martin, John B., NRTA/AARP, quote, lifetime learning *171*
Mary Scranton Foundation, Inc., Dr. William Triebel ..... FAP 174
Mary Scranton Clinic, The, Dr. William Triebel ..... FAP 74
Massachusetts:
  Aging activities *179*
  Association of Older Americans, Inc., Walter H. Cross, letter ..... ILR 194
  Bar Association, Edward W. Gorfine, statement ..... ILR 200
  Department of Elder Affairs, J. J. Donovan, statement ..... ILR 166
Mathews, David, HEW, letters from Senator Frank E. Moss and Representative Claude Pepper ..... PHH 165
Maximum allowable cost program *156*
Medicaid:
  Administration cost, State versus intermediaries ..... MMF 28
  Benefits, Payment delays cause hardships ..... FAP 191
  Care, quality questionable ..... FAP 191
  Clinical laboratories:
    Fees, private versus public ..... MMF 419, 436, 445
    Fee schedules antiquated ..... MMF 418, 445, 456, 465, 467
    Illinois investigation ..... MMF 417
    Kickbacks ..... MMF 414
    Payments, table ..... MMF 467
    Tests, billing practices ..... MMF 418
    Tests, overutilization ..... MMF 428
  Committee recommendations ..... FAP 222
  Computerized control lacking ..... FAP 104
  Cost of program, GAO report ..... PHH 41
  Costs:
    Dispersion of funds ..... FAP 5
    Increase, statistics ..... FAP 5
  Drugs:
    Generic substituted ..... MMF 272, 358
    Maximum allowable cost program *156*
  Elderly:
    Health costs and problems *23*
    Out-of-pocket payments increase, causes *24*
  "Explanation of Medicare Benefits," required ..... FAP 143
  Factoring:
    Causes, effects ..... MMF 41
    Organized crime infiltration ..... MMF 48
    Outlawed *32*
    State indifference ..... MMF 55
  Factors:
    Bills increased by ..... MMF 49
    Lobbyist, use of ..... MMF 50
  Federal:
    Responsibility ..... FAP 197
    Standards ..... FAP 198
  Fee-for-services system ..... PHH 26
  Fountain report, findings ..... FAP 200
  Fund conservation, Michigan efforts ..... MMF 10
  Frauds ..... PHH 25
    Audits, return on investment ..... MMF 12, 14
    California, findings ..... PHH 34

NOTE: See page 223 for guide to code abbreviations.

Medicaid—Continued
Frauds—Continued
Cases reported, table ---- FAP 207
Chiropractors ---- FAP 76
Clinical laboratories ---- *26*
Clinical labs, billing practices ---- MMF 418, 451, 464
Clinical laboratory kickbacks:
Defined ---- MMF 432
Methods used ---- MMF 414, 418, 426
Percentage paid ---- MMF 426
Proposition revealed ---- MMF 420, 425
Clinical laboratories, leasing arrangements ---- MMF 431
Clinical laboratories, overutilization ---- MMF 79
Clinical labs, subcontracting of tests ---- MMF 450, 464
Dentists ---- FAP 76
Deterrents suggested ---- MMF 82
D. J. Medical Laboratory bills submitted to Illinois Department of Public Aid ---- MMF 469
Federal regulation needed ---- MMF 24
Federal role ---- MMF 32
Illinois investigation ---- MMF 270
Clinical laboratories, tests unauthorized ---- MMF 270
Computer program established ---- MMF 293
Factoring firms favored ---- MMF 243, 251, 359
Favoritism denied ---- MMF 301, 312, 329, 345
GAO audits opposed ---- MMF 238
Charge denied ---- MMF 294, 319
GAO, evidence withheld from ---- MMF 238, 242, 244, 251
GAO, evidence withheld charge denied ---- MMF 295, 319, 325, 328
Goff testimony rebutted ---- MMF 292, 307, 312, 324, 376
Hatch act violation cited ---- MMF 234, 240
Hatch act violation denied ---- MMF 298, 316
Illinois Department of Public Aid, positive actions taken ---- MMF 292
Material sent to U.S. Attorney General by Sen. Frank E. Moss ---- MMF 387
Political interference charged ---- MMF 234
Political interference denied ---- MMF 352, 363, 374, 378
State–GAO cooperation cited ---- MMF 294
Intermediaries use curtailed ---- MMF 28
Investigation, committee conclusions ---- FAP 209
Investigative responsibility ---- PHH 58
Investigative staff inadequate ---- PHH 59
Investigative unit established ---- *39*
Investigators, expertise required ---- MMF 458
IRS code, provisions ---- MMF 431
Kickbacks:
Defined ---- MMF 432
Methods used ---- MMF 414, 418, 426
Percentages paid ---- MMF 426
Proposition revealed ---- MMF 420, 425
Laboratories ---- MMF 16
Methadone clinics, maintenance ---- FAP 73, 173
Michigan:
Department of Social Services, report ---- MMF 85
Efforts to control ---- MMF 12
Experience ---- MMF 9
Mills, Senate investigation ---- FAP 1
New Jersey investigation ---- MMF 449, 463
New York cases, disposition of, tables ---- FAP 243, 255
New York City, typical disciplinary actions ---- FAP 179
New York State, penalties provided ---- FAP 125
Northeast Community Hospital, Chicago ---- MMF 58
Nursing homes ---- MMF [illegible], 14, 16
Optometrists and opticians ---- FAP 76

NOTE: See page 223 for guide to code abbreviations.

Medicaid—Continued
Frauds—Continued
Organized crime involvement ..... MMF 454
Percentage leasing ..... MMF 432
Pharmacies ..... FAP 80, MMF 16
Kickbacks ..... MMF 262
Percentage leasing ..... MMF 433
Physicians ..... FAP 76
Use of assistants ..... MMF 23
Podiatrists ..... FAP 76
Practitioners ..... FAP 1, MMF 15, 23
Percentage small *28*
Preventive methods ..... MMF 31
Prosecution difficult ..... MMF 17, 20
Lacking ..... MMF 244, 371, 419
State and Federal prosecutors, comments *31*
Statute passed ..... MMF 419
Storefront clinic opened ..... MMF 423
Surgery, unnecessary ..... MMF 68
Utilization review ..... PHH 54
Von Solbrig hospital, alleged ..... MMF 67
GAO report, findings ..... FAP 199
HEW's reaction to criticism ..... FAP 208
HEW regulations clarified ..... PHH 52
HEW report, "Development of Medicaid Provider Abuse Detection program," findings, recommendations ..... FAP 105
Health legislation introduced *122*
Home health care:
Eligibility categories ..... PHH 64, 70
Expansion needed ..... PHH 109
Legislative efforts *35*
Pennsylvania study, cost, statistics ..... PHH 115
Progress *34*
Home health regulations, proposed changes ..... PHH 48
Home health services ..... ADF 36
Now available ..... PHH 62
Homemaker training costs ..... PHH 28
Identification cards, lack of control ..... FAP 106
Kickbacks, political ..... MMF 48
Medical Society of County of New York, response to committee inquiry ..... FAP 196
Medicare, merger advocated ..... FSS 2093
Methadone maintenance, expenses ..... FAP 173
Mills:
Abuses enumerated, defined ..... FAP 18
Buying, selling described ..... FAP 60
Care, quality described ..... FAP 32
Committee conclusions ..... FAP 209
Conditions ..... FAP 80
Dentists, fee-splitting ..... FAP 72, 151
Percentage leasing ..... FAP 72, 151
Fee-splitting ..... FAP 66, 151
Financial and operational aspects ..... FAP 48
Illinois, physician involvement ..... FAP 45
Investigation begun *29*
Methods used *30*
Kickbacks ..... MMF 414
Moss, Senator Frank E., experiences ..... FAP 34
New York investigation *29*
Number increasing ..... FAP 43
Ownership ..... FAP 19, 46, 60
Payments estimated ..... FAP 43
Percentage leasing ..... FAP 66, 151
Pharmacists, fee-splitting ..... FAP 70, 151
Percentage leasing ..... FAP 70, 151

NOTE: See page 223 for guide to code abbreviations.

Medicaid—Continued
Mills—Continued
Physicians, cheating methods ..... FAP 58
Described ..... MMF 414
Employment, procedure ..... FAP 50
Financial arrangements ..... FAP 80
Involvement ..... FAP 45
Typical, description ..... FAP 13
Working conditions ..... FAP 56
Renting, leasing arrangement ..... FAP 61, 66
Senate investigators, experiences ..... FAP 26
Shopping experiences related ..... FAP 20
Typical, description ..... FAP 12
New York City:
Audits, findings ..... FAP 183
Audit staff inadequate ..... FAP 181
Eligibility check lacking ..... FAP 186
Enforcement system inadequate ..... FAP 177
Fiscal crisis, relationship ..... FAP 108
Fraud control lacking ..... FAP 182
Ineligibles, cost of ..... FAP 104
Reimbursement claims ..... FAP 184
Welfare, eligible-ineligible percentages ..... FAP 185
New York State:
Agencies, fund management responsibilities ..... FAP 120
Attorney general, position stated ..... FAP 160
Computerization of program ..... FAP 175
Dental Society, response to committee inquiry ..... FAP 195
Department of Audit and Control, organization, functions ..... FAP 161
Department of Education:
Investigative staff inadequate ..... FAP 154
Organization, functions ..... FAP 149
Department of Health:
Medical facility rates regulated ..... FAP 136
Regulations, enforcement responsibility ..... FAP 137
Department of Law, organization, functions ..... FAP 158
Eleventh District Dental Society, response to committee inquiry ..... FAP 196
Enforcement inadequate ..... FAP 144, 150
Expenditures ..... FAP 8
First District Dental Society, response to committee inquiry ..... FAP 195
Investigations, reports ..... FAP 87
Local health districts, responsibilities, failings ..... FAP 171
Medicaid Management Information System ..... FAP 87, 103, 118, 143, 176
Medical care quality regulated ..... FAP 130
State Medical Handbook, regulations, provisions ..... FAP 137
Nursing homes, licensed and regulated ..... FAP 135
Office of Welfare Inspector General, organization, functions FAP 166
Payments, recording requirements ..... FAP 127
Physicians:
Discipline provisions inadequate ..... FAP 149, 153
Percentage rentals, regulations pertaining to ..... FAP 258
Receiving more than $100,000 ..... FAP 10, 231
Program Costs, statistics ..... FAP 109
Regional health offices, responsibilities, failings ..... FAP 171
Regulations, enforcement responsibility shared ..... FAP 141
Reimbursement claims ..... FAP 184
Social Service Districts, financing ..... FAP 168
Nursing homes:
Audits by State, tables ..... FAP 203
Audits lacking ..... MMF 2
Kansas investigation, findings ..... MMF 255

NOTE: See page 223 for guide to code abbreviations.

Medicaid—Continued
Nursing homes—Continued
Patient personal accounts:
Abused ---- MMF 30, 220
Audits, findings ---- MMF 226
HEW requirements ---- MMF 225
Mismanagement ---- MMF 223
Poor care profitable ---- *48*
Standards:
Enforcement legislation introduced ---- *51*
Not enforced ---- *51*
Improvement proposed ---- *50*
Lower ---- PHH 11, 15
Pharmacies, abuses ---- FAP 19
Physicians:
Assignment refused ---- *24*
Committee conclusions ---- FAP 209
Receiving more than $100,000 during 1974, list ---- FAP 227
Practitioners, conflict of interest ---- PHH 32
Prepaid health plans ---- PHH 26
Program growth, statistics ---- FAP 5
Professional Societies, role of ---- FAP 194
Proprietary home health care:
Auditing, responsibility of ---- PHH 69
Corporations eligible, problems ---- PHH 30
Funds available ---- PHH 54
Service program ---- PHH 6, 8, 23
Reimbursement of agencies ---- PHH 67
Regulations, improvements suggested ---- PHH 148
Rural elderly, inaccessibility ---- *40*
State's rights ---- PHH 12, 15
SSI recipients automatically eligible ---- FAP 191
Voucher system advocated ---- PHH 19
Medical Facilities, Inc. (Bronx, N.Y.), Owen McCormack ---- FAP 72
Medical Personnel Pool of America, Inc.:
Medical pool, typical, statistics ---- PHH 87
Smith, John B., statement ---- PHH 83
Medical Services Finance Companies ---- MMF 43
Medical schools, geriatric programs few ---- *105*
Medicare:
Automatic eligibility ---- TSS 11
Benefits shrinking ---- MMF 8
Deductibles increase ---- FSS 2094, *25*
Drugs, maximum allowable cost program ---- *156*
Elderly, deductible increase ---- FSS 2066, 2091
Health costs and problems ---- *23*
Factoring, causes, effects ---- MMF 41
Outlawed ---- *32*
Frauds:
Practitioners, percentage small ---- *28*
Investigative unit established ---- *39*
Nursing homes, examples ---- MMF 1
State and Federal prosecutors, comments ---- *31*
Health legislation introduced ---- *122*
Home health care ---- ADF 36
Abuse alleged ---- PHH 130, 137
Legislative efforts ---- *35*
Pennsylvania study, cost, statistics ---- PHH 115
Progress ---- *34*
Services now available ---- PHH 62
Hospital insurance protection ---- TSS 11
Hospitals, redtape increases cost ---- FSS 2160
Improvement suggestions ---- *39*

NOTE: See page 223 for guide to code abbreviations.

Medicare—Continued
Nursing homes:
Medicaid, merger advocated ..... FSS 2093
National health insurance experience *38*
Kansas investigation, findings ..... MMF 255
Numbers increased *43*
Patient accounts mismanaged ..... PHH 36
Poor care profitable *48*
Regulations more stringent ..... PHH 11, 15
Standards enforcement legislation introduced *51*
Improvement proposed *50*
Not enforced *51*
Paraprofessionals not accepted *41*
Proprietary home health service program ..... PHH 6, 8, 23
Regulations, improvements suggested ..... PHH 147
Rural elderly disadvantaged *40, 122*
Supplementary medical insurance protection ..... TSS 12
Memphis (Tenn.) Senior Citizens Service, Robert Rochelle, letters ..... FSS 2191
Mental health:
Center for Studies of Mental Health of the Aging, established *107*
The role of nursing homes, reports *46*
Mental patients:
Boarding homes, for profit, conditions *27*
Nursing home role *46*
Mermaid Medical Building Realty Corp.:
Greene, George ..... FAP 70
Sack, Cyril ..... FAP 66, 70
Merrimack Valley Home Care Center:
Madio, Daniel, statement ..... ILR 202
Casey, Thomas, statement ..... ILR 192
Methadone, Medicaid fraud, clinic maintenance ..... FAP 73, 173
Meyer, Dr. Herbert, Chicago physician ..... MMF 420
Michigan:
Bureau of Medical Assistance, Donn Moffitt, statement ..... MMF 9
Department of Social Services:
Allen, Paul M., statements ..... MMF 9, 35
Medicaid fraud investigation, report ..... MMF 85
Medicaid fraud, efforts to control ..... MMF 12
Experiences ..... MMF 9
Medicaid Program Integrity Division, John Neidow, statement ..... MMF 9
Medical Society, minutes, excerpt re Medicaid overcharges ..... MMF 19
Miller, Lloyd, National Association of Retired Federal Employees, statement ..... FSS 2188
Minorities:
Elderly:
Committee conclusions *143*
Employment *137*
Suffer more *132*
Major actions affecting *136*
White House Conference recommendations *206*
Nursing homes, access to, report *47*
Poverty by race, tables *132, 133, 134*
Social security, blacks underrepresented *135*
SSI benefits, by race, table *135*
Minority views of Messrs. Domenici, Brooke, and Percy *209*
Mitchell, Dr. George, Illinois Medical Society Advisory Committee ..... MMF 304
Moakley, Representative Joe, statement ..... ILR 143
Moffitt, Donn, Bureau of Medical Assistance, Lansing Mich., statement ..... MMF 9
Montefiore Hospital, NYC, after care program ..... ADF 29
Moore, Donald Page, Illinois Governor's Medical Payments Task Force ..... MMF 235, 299, 325
Statement ..... MMF 376

NOTE: See page 223 for guide to code abbreviations.

83-453 O - 77 - 18

Moore, Florence, National Council for Homemaker-Home Health Aide Services, Inc., letters ..... PHH 254, 258
Moreland Commission on Nursing Homes and Residential Facilities, N.Y. ..... FAP 93, 101, 145, 158
Morgan, Edmond L., Illinois Association of Clinical Laboratories, statement ..... MMF 79, 129
Morris, Richard, Public Affairs Research Organization ..... FAP 116
Moss, Senator Frank E.:
Letters to David Mathews ..... PHH 165
Letters to past and present New York public officials ..... FAP 234
Medicaid investigation, Illinois; material sent to attorney general ..... MMF 387
Medicaid mill experiences ..... FAP 34
Nursing home legislation introduced 47
Quotes:
Boarding home conditions 27
Fraud among physicians 28
Statements ..... MMF 1, 219, 287, 409, PHH 1, L-T 3317, NHF 1
Multnomah County (Oreg.) Division of Public Safety 130
Mulvey, Dr. Mary, NCSC, statement ..... FSS 2090
Municipal Assistance Corp., Felix Rohatyn ..... FAP 111
Municipalities:
Retirement, staff plans, benefits exemplified ..... TSS 17
Social security:
Withdraw from system, factors to consider, recommendations ..... TSS 22, 28
Withdraw from system, reasoning ..... TSS 1, 19
Murawski, Dr. Thaddeus J., letter to Senator Frank E. Moss ..... FAP 263
Murphy, Emily M., statement ..... ILR 185
Muskie, Sen. Edmund, statement ..... MMF 3
Myers, Beverlee ..... FAP 104

N

Nagy, Joseph, former Kane Hospital nurses' aide, statement ..... L-T 3434
Narco Freedom, Inc ..... FAP 17,74
Nash, Dr. Seymour L., letter to Senator Frank E. Moss ..... FAP 269
Nathanson, Paul, National Senior Citizens Law Center, source of funds 195
National Association of Counties, aging activities 190
National Association of Home Health Agencies:
Byrne, John, statement ..... PHH 146
Trautman, Don, statement ..... PHH 146
Statement ..... PHH 215
National Association of Housing and Redevelopment Officials:
Resident manager certification 63
Housing recommendations 60
National Association of Retired Federal Employees, Lloyd Miller, statement ..... FSS 2188
National Bureau of Standards, letter ..... NHF 183
National Center for Housing Management, resident manager certification 63
National Center on the Black Aged, section 202 funds, use of 136
National Council for Homemaker-Home Health Aide Services, Dr. Ellen Winston, statement ..... PHH 100
National Council of Senior Citizens:
Bergman, James A., statement ..... ILR 173, 178
Boston legal research and services program ..... ILR 173, 178
Crime prevention efforts 130
Mulvey, Dr. Mary, statement ..... FSS 2090
National health insurance proposal 39
National Council for Homemaker-Home Health Aide Services, Inc.:
Moore, Florence, letters ..... PHH 254, 258
Policy statement ..... PHH 263
Revised draft of bill ..... PHH 265
Statement ..... PHH 100

NOTE: See page 223 for guide to code abbreviations.

National Fire Protection Association:
Best, Richard L., statement ..... NHF 72
Grimes, Martin ..... NHF 72
Sharry, John ..... NHF 72
National Funeral Directors Association *159*
National health insurance program *38*
AARP proposal *39*
NCSC proposal *39*
National Indian Council on Aging, formed, funded *138*
National Institute on Aging:
Aging research supported *102*
Butler, Robert, quote, train for research *103, 104, 105*
Future directions *103*
National League for Nursing, Nancy Tigar, statement ..... PHH 108
National Retired Teachers Association/American Association of Retired Persons:
Brickfield, Cyril F., letter ..... PHH 243
Crime prevention efforts *130*
Elderly tax aide program ..... ILR 162
Funeral costs, position *158*
Peace, James S., statement ..... ILR 156, 160
Rosenthal, Julian B *160*
Stevenson, Leon, statement ..... FSS 2156
Neal, Cynthia, Providence, R.I., statement ..... FSS 2119
Neidow, John, Medicaid Program Integrity Division, Lansing, Mich., statement ..... MMF 9
New England Elderly Demand Society, Beth Taylor, statement ..... FSS 2104
New Hampshire legal aid program ..... ILR 176, 180
New Jersey:
Commission of Investigation:
Dickson, Anthony G., letter ..... MMF 516
Statement ..... MMF 449
Holstein, Frank L., statements ..... MMF 449, 463
Department of Institutions and Agencies, Gerald J. Reilly, letter ..... MMF 515
Medicaid investigation ..... MMF 449, 463
New York City:
Department of Health ..... FAP 69
Dr. Martin Paris ..... FAP 120
Lowell E. Bellin ..... FAP 89
Department of Social Services ..... FAP 93
Rosner, Henry ..... FAP 17
Employees, withdraw from social security system ..... TSS 1
Fiscal crisis, relation to Medicaid program ..... FAP 108
Laurence, Stuart, medicaid investigator ..... FAP 178
Medicaid:
Audit staff inadequate ..... FAP 181
Audits, findings ..... FAP 183
Costs, statistics ..... FAP 109
Eligibility check lacking ..... FAP 186
Enforcement system inadequate ..... FAP 177
Fraud control lacking ..... FAP 182
Frauds, typical disciplinary actions ..... FAP 179
Ineligibles, cost of ..... FAP 104
Reimbursement claims ..... FAP 184
Welfare, eligible-ineligible percentages ..... FAP 185
Methadone maintenance, cost to Medicaid ..... FAP 173
Senior citizen robbery unit *127*
Welfare load, increase ..... FAP 185
New York, County of:
"Report of the Fourth November 1969 Grand Jury," findings ..... FAP 90
Medical Society, response to committee inquiry ..... FAP 196

NOTE: See page 223 for guide to code abbreviations.

New York State:
Aging activities ... *179*
Attorney general, position stated ... FAP 160
Audit of New York City Agencies, findings ... FAP 98
Board of Social Welfare, responsibilities ... FAP 156
Coalition for Home Health Services, Janet E. Starr, statement ... PHH 118
Comptroller:
Duties of ... FAP 161
Position stated ... FAP 162
Department of Audit and Control, organization, functions ... FAP 161
Department of Education:
Amendments to the regulations of the commissioner ... FAP 260
Bardo, August J. Jr ... FAP 68, 151
Investigative staff inadequate ... FAP 154
Organization, functions ... FAP 149
Stone, Robert ... FAP 69
Department of Health:
Auditors, staff inadequate ... FAP 144
Medicaid regulations, enforcement inadequate ... FAP 144, 150
Medicaid regulations, enforcement responsibility ... FAP 137, 141
Medical facility rates regulated ... FAP 136
Organization, functions ... FAP 133
Warner, Dr. George, statement ... PHH 29
Department of Law, organization, functions ... FAP 158
Department of Social Services:
Auditors, staff inadequate ... FAP 144
Berger, Stephen ... FAP 120
Medicaid regulations, enforcement:
Inadequate ... FAP 144, 150
Responsibility shared ... FAP 141
Organization, functions ... FAP 122
Division of the Budget, responsibilities ... FAP 156
Eleventh District Dental Society, response to committee inquiry ... FAP 196
Emergency Financial Control Board ... FAP 108, 117
First District Dental Society, response to committee inquiry ... FAP 195
Fiscal crisis, relation to Medicaid program ... FAP 108
Hospital Utilization Review Program, described ... FAP 172
Local health director, responsibility ... FAP 137
Local health districts, responsibilities, failings ... FAP 171
Medicaid:
Care, quality regulated ... FAP 130
Computerization of program ... FAP 175
Costs, statistics ... FAP 109
Expenditures ... FAP 8
Fraud cases, disposition, tables ... FAP 243, 255
Fraud, penalties provided ... FAP 125
Fund management, agencies responsible, jurisdiction ... FAP 126
Payments, recording requirements ... FAP 127
Physicians receiving more than $100,000 ... FAP 10, 231
Reimbursement claims ... FAP 184
Mill investigation ... *29*
Medicaid Management Information System ... FAP 87, 103, 118, 143, 176
Medicare, Medicaid investigations, reports ... FAP 87
Medical Society, position on "fee-splitting" ... FAP 67
Moreland Commission on Nursing Homes and Residential Facilities ... FAP 93, 101, 145, 158
Nursing homes:
Kickbacks ... *31*
Licensed and regulated ... FAP 135
Public Health Council ... PHH 29
Office of Welfare Inspector General, established ... FAP 92
Findings ... FAP 97, 99
Functions ... FAP 166

NOTE: See page 223 for guide to code abbreviations.

New York State—Continued
Physicians:
Discipline provisions inadequate ..... FAP 149, 153
Percentage rentals, regulations pertaining to ..... FAP 258
Professional societies, positions ..... FAP 194
Regional health offices, responsibilities, failings ..... FAP 171
Social Services Districts, financing ..... FAP 168
Social Service Law, provisions ..... FAP 169
State Medical Handbook, regulations, provisions ..... FAP 137
Temporary Commission to Revise the Social Services Law, findings FAP 100, 103
Norsom Medical Reference Laboratory ..... MMF 436
Northeast Community Hospital, Chicago:
Conditions described ..... MMF 66
Medicaid fraud alleged ..... MMF 58
Patient admitting policies questioned ..... MMF 58
Northside Clinical Laboratory, Nemie LaPena ..... MMF 427, 436
Northeast Community Hospital, Chicago:
Patient recruitment tactics used ..... MMF 58, 71
Response to allegations ..... MMF 150
Nursing homes:
Bed availability, discrimination ..... ILR 166
Federal role in upgrading 43
Fire safety:
Code compliance ..... NHF 28, 29, 36, 38
Comptroller General report ..... NHF 124
Corridors, dead-end ..... NHF 4
Doors, self-closing ..... NHF 8, 68, 69
Electrical wiring ..... NHF 79
Evacuation of residents ..... NHF 16
Fire-resistant furnishings ..... NHF 39
Fire test report ..... NHF 338
Flammability standards, floor coverings ..... NHF 296
Flammability testing ..... NHF 65
Flammable furnishings ..... NHF 4
Human error ..... NHF 37
Industry involvement ..... NHF 64
Legislation recent ..... NHF 10
Lighting, emergency ..... NHF 80
Loan application procedures ..... NHF 49
Loan applications, waivers ..... NHF 58
Respirators, usefulness ..... NHF 20
Smoke detectors ..... NHF 25, 71
Smoke detectors, cost estimate, report ..... NHF 340
Smoke, toxic ..... NHF 8, 9, 66–69, 75, 77
Sprinklers:
Importance of ..... NHF 7, 43, 71, 77, 78
Installation ..... NHF 30, 46, 47
Loan insurance ..... NHF 31–33, 41
Standards, NFPA ..... NHF 73
Fires, report 45
GAO fire report ..... NHF 5, 11
Geriatric training 49
HEW, patient personal accounts, regulations lacking ..... MMF 221
Home health care, cost comparison ..... PHH 43
Institutionalization, alternatives ..... PHH 49
Inventory of health care facility surveyors ..... NHF 229
"Kane Hospital, A Place To Die," report ..... L–T 3321
Kansas investigation:
Findings ..... MMF 255
Staff inadequate ..... MMF, 255, 260
Legislation introduced 47

NOTE: See page 223 for guide to code abbreviations.

Nursing homes—Continued
Medicaid:
Audits by State, tables ... FAP 203
Audits lacking ... MMF 2
Frauds ... MMF 14, 16
Examples ... MMF 1
Patient personal accounts, mismanagement ... MMF 223
Standards lower ... PHH 11, 15
Medicare enhances number ... 43
Medicare regulations more stringent ... PHH 11, 15
Minorities, access to ... 47
National Bureau of Standards, letter ... NHF 183
New York:
Kickbacks ... 31
Licensed and regulated ... FAP 135
Nurse training ... 49
Patients:
Accounts mismanaged ... PHH 36
Bill of rights ... 187
Funds abused ... MMF 30
Legal aid, ombudsman project ... ILR 166
Personal acounts abused ... MMF 220
Personal accounts, HEW requirements ... MMF 225
Statistics ... xv
Pharmacies, kickbacks ... FAP 89, MMF 26, 262
Physician training ... 49
Physicians, "gang visits" ... FAP 88
Poor care profitable ... 48
Profits, pro and con, report ... 47
Organized crime infiltration ... MMF 27
Reports, summary ... 44
Social Security, benefit payments directly to ... PHH 36
Staff training procedures ... NHF 35
Standards:
Enforcement legislation introduced ... 51
Improvement proposed ... 50
Not enforced ... 51
State agencies on aging, activities ... 186
Training legislation introduced ... 49
Upgrading, legislation introduced ... 50
Wincrest Nursing Home fire, report ... NHF 326
Nurses, nursing homes:
Report ... 45
Training ... 49
Nutrition:
Congregate meals, statistics ... 75
Elderly:
Funding increased ... 73
Programs ... FSS 2082
Older Americans Act, title VII funding levels by State, table ... 74
Meals-on-wheels program ... 75

O

Older Americans Act:
Adult day facilities, financing ... 37
Aging programs, growth in numbers and dollars ... 67
Committee findings and recommendations ... 84, 117
Funding increases, table ... 68
Legal assistance provided ... ILR 158
Title III:
Evaluation ... 72
Funding levels by State, table ... 70
Funds, use ... 182

NOTE: See page 223 for guide to code abbreviations.

Older Americans Act—Continued
Title III—Continued
Legal service funds ... *192*
Program progress ... *69*
Title IV:
Multidisciplinary centers, grants enumerated ... *116*
Section 308 projects ... *193*
Training grants ... *109*
Schools receiving, list ... *110*
Title IV–B. research grants ... *112*
Title V funding, purpose ... *76*
Title VII:
Funding increased ... *73*
Funding levels by State, table ... *74*
Program, evaluation ... *75*
Title IX Older American Community Service Employment Act, funding ... *89*
Title XX:
Agreements, use of funds ... *180*
Funding by State, table ... *80*
Funds, use of ... *77*
Means test regulations ... *79*
Problems ... *78*
White House Conference recommendations ... *202*
Older American Community Service Employment Act, title IX ... *137*
Older Americans Tax Counseling Assistance Act, introduced ... *168*
Old Colony Elderly Service, Inc., Paul V. Casey, letter ... ILR 199
Omega Clinic, Detroit, Mich ... FAP 29
164th Street Medical Clinic, New York City ... FAP 27, 39
O'Neill, Rep. Thomas P., statement ... ILR 140
Optometrists and opticians, medicaid frauds ... FAP 76
Oriol, Patricia, Senate investigator ... FAP 26, 29, 31, 86

P

Pacific Asian Elderly Research project, The ... *142*
Panebianco, Thomas, Parsons Group, Inc ... FAP 71
Paralegals. (*See* Legal services.)
Paraprofessionls, medicare will not accept ... *41*
Park Medical Laboratory ... MMF 452
Parke-Dewatt Laboratory ... MMF 430
Paris, Dr. Martin, New York City Department of Health ... FAP 120
Parochial Employees' Retirement System of Louisiana ... TSS 34
Parro, Robert C ... FAP 46, MMF 429
Parsons Group, Inc., Thomas Paneblanco ... FAP 71
Pastore, Senator John O., statement ... FSS 2068
Peace, James S., NRTA/AARP, statement ... ILR 156, 160
Pedgrift, Judy, United Medical Laboratory ... MMF 428
Peeples, Ben, First Tennessee-Virginia Development District Area Agency on Aging, statement ... FSS 2189
Pell, Senator Claiborne, statement ... FSS 2069
Pennsylvania State Department of Health, medicare-medicaid inspection of Kane Hospital, report ... L–T 3471
Pensions:
Employee Retirement Income Security Act ... *171*
Reporting and disclosure ... *173*
Pension Benefit Guaranty Corp., responsibilities ... *172*
Peoples Medical Center, Brooklyn, N.Y ... FAP 29
Pepper, Representative Claude:
Letter to David Mathews, HEW ... PHH 165
Medicaid legislation introduced ... *36*
Statements ... PHH2, NHF 5
Percy, Senator Charles H.:
Minority views ... *209*
Quote, geriatric questionnaire ... *105*
Statements ... MMF 4, 230, 288, 411, PHH 43, L–T 3458, NHF 6

NOTE: See page 223 for guide to code abbreviations.

Perrotta, Ralph, Federal Advisory Commission on Legislation, statement ..... FSS 2119
Pfau, Mary Ann, American Nurses' Association, statement ..... PHH 121
Pharmacies:
Clinical laboratories, percentage leasing ..... MMF 433
Illinois investigation ..... MMF 270, 358,
Kickbacks to nursing homes ..... MMF 26
Medicaid abuses ..... FAP 19, 80, MMF 16
Nursing homes, kickbacks ..... FAP 89, MMF 262
Pharmacists, fee-splitting, percentage leasing ..... FAP 70, 151
Phelan, John, attorney ..... FAP 16
Phillips, Lillie M., Memphis, Tenn., statement ..... FSS 2179
Physicians:
Clinical laboratories, kickbacks ..... MMF 414
Clinical laboratories, percentage leasing ..... MMF 432
Illinois investigation ..... MMF 271
Kane hospital, indifferent ..... L–T 3424
Kane hospital, understaffed ..... L–T 3424
Medicaid:
Assignment refused 24
Conflict of interest ..... PHH 32
Frauds ..... FAP 76
Frauds, use of assistants ..... MMF 23
Mills:
Cheating methods ..... FAP 58
Described ..... MMF 414
Employment procedure ..... FAP 50
Fee-splitting ..... FAP 66, 151
Financial arrangements ..... FAP 80
Involvement ..... FAP 45
Percentage leasing ..... FAP 66, 151
Typical, description ..... FAP 13
Working conditions ..... FAP 56
Slow billing deters participation ..... FAP 192
Medicare frauds, percentage small 28
Nursing homes, "gang visits" ..... FAP 88
Nursing home responsibilities, report 45
Nursing home training 49
Percentage rentals, New York State regulations pertaining to ..... FAP 258
Receiving more than $100,000 from medicaid during 1974, list ..... FAP 227
Rural shortage 41
"Ping-ponging", defined ..... FAP 18
Piscioneri, James P., Springfield (Mass.) Home Care Corp., letter ..... ILR 196
Pittsburgh (Pa.) Action Coalition of Elders:
Cobbs, William C., Sr., statement ..... L–T 3319
Silverstein, Harold H., statement ..... L–T 3439
Pittsburgh (Pa.) Free Clinic, Mary Lewin, statement ..... L–T 3424
Pittsley, George, GAO, statement ..... MMF 220
Podiatrists, medicaid frauds ..... FAP 76
Pollard, Rev. William, Wincrest Nursing Home, statement ..... NHF 12
Population, U.S.:
Asian-Americans, efforts in behalf 142
Elderly:
Aged 65 plus, by State, statistics xix
Automobile ownership, statistics xviii
Educational attainment xvii
Employment statistics xvii
Health cost per capita, statistics xv
Health status, statistics xiv
Life expectancy, statistics xvi
Living arrangements xvii
Marital status, statistics xvi
Minorities, committee conclusions 143

NOTE: See page 223 for guide to code abbreviations.

Population, U.S.—Continued
Elderly—Continued
Mobility, statistics xvii
Personal income, disposition xv
Place of residence, statistics xvii
1776 to present, statistics xiii
Sex ratio, statistics xvi
Voter participation, statistics xvii
Indians and Native Alaskans, health needs 138
Minorities in poverty 132
Nursing home patients, statistics xv
Projections to year 2000, tables xviii
Spanish-speaking elderly, efforts in behalf 141
Poverty level:
Computation methods 5
Elderly, by age and sex, table ..... RCV 11
Elderly minorities suffer more 132
Elderly, thresholds, table 4
Practitioners:
Conflict of interest ..... PHH 32
Medicaid frauds ..... MMF 15, 23
New York medicaid fraud cases, disposition, tables ..... FAP 243, 255
Prendergast, James Terence, Staff Builders, statement ..... PHH 157
Prepaid health plans ..... PHH 26
Professional Medical Guidance Corp ..... MMF 43
Professional Societies, role in medicaid ..... FAP 194
Proprietary Home Health Care:
Advantages cited ..... PHH 157
Agencies, inadequate supply ..... PHH 55
California low bidder loses ..... PHH 163
Certificate of need requirement ..... PHH 142
Cost comparison ..... PHH 25
Costs, figures misleading ..... PHH 132, 139
Cost-quality relationship ..... PHH 136
Eligibility of individuals ..... PHH 55
Employee bonding ..... PHH 154
For-profit defined ..... PHH 37
HEW proposed regulations:
Abuse potential great ..... PHH 36
Care quality increased ..... PHH 86
Opposed ..... PHH 6, 9, 15, 18
Homemaker training, cost ..... PHH 28
Medicaid:
Auditing, responsibility of ..... PHH 69
Corporations, eligible ..... PHH 30
Funds available ..... PHH 54
Regulations clarified ..... PHH 52
Reimbursement of agencies ..... PHH 67
Profit motive necessary? ..... PHH 124
Profit-nonprofit cost comparison ..... PHH 143
Profits, source of ..... PHH 130, 136
Regulations lacking ..... PHH 92
Round-the-clock service needed ..... PHH 71, 76, 89
Service program ..... PHH 6, 8, 23
Skimming practice ..... PHH 127
Standards ..... PHH 24
State licensure ..... PHH 49, 68, 78, 89, 98, 113, 141, 153, 159
Supervision maintains high standards ..... PHH 158
Underbid volunteer organizations ..... PHH 126
Unlicensed, proposed regulations ..... PHH 267
Providence Journal, articles ..... FSS 2136
Providence (R.I.) Project Hope, Dorothy Craighead, statement ..... FSS 2082

NOTE: See page 223 for guide to code abbreviations.

Public Affairs Research Organization, Richard Morris ..... FAP 116
Public Buildings Cooperative Use Act, provisions *162*
Public Interest Law Center of Philadelphia, class action suit *96*
Public Works and Economic Development Act:
Emergency Jobs Programs Extension Act *91*
Title X Job Opportunities Program *91*

Q

Queens County (N.Y.) Medical Society, Dr. Morton Kurtz ..... FAP 66

R

Railroad Retirement Board, SSI, cooperation with *145*
Rakofsky, Dr. Max, 80 Delancy Medical Center ..... FAP 82, 85
Randall, Rep. William J., statement ..... PHH 45
Rawlinson, Helen L., Blue Cross of Greater Philadelphia, statement ..... PHH 115
Recession:
Elderly, effect on ..... RCV 1, *85*
"Recession's Continuing Victim: The Older Worker," a working paper by Marc Rosenblum ..... RCV 1
Recktenwald, William A., investigator, statement ..... MMF 317, 420
Reese, Eva M., Visiting Nurse Service of New York:
Letter ..... PHH 257
Statement ..... PHH 111
Reeves, Mary Bell, Memphis, Tenn., statement ..... FSS 2165
Reger, Ernest, Providence, R.I., statement ..... FSS 2088
Rehabilitation Act of 1973, section 504, provisions *164*
Reilly, Gerald J., New Jersey Department of Institutions and Agencies, letter ..... MMF 515
Reiter, Dr. B. P., magazine article ..... FAP 50
Retirement:
Budget, hypothetical, table *3*
Employee Retirement Income Security Act *171*
ERISA, reporting and disclosure *173*
Staff plans, benefits exemplified ..... TSS 17
Social security, value of ..... TSS 9
Revenue sharing plan ..... FSS 2091, 2094
Rhode Island:
Aging activities *179*
Council of Senior Citizens:
Creighton, Frederick W., statement ..... FSS 2079
Curley, Mrs., statement ..... FSS 2103
Gray Panthers, Michael Boday, statement ..... FSS 2105
Group Health Association ..... FSS 2090
Membership, benefits ..... FSS 2097
Institute of Mental Health, Jim Keegan, statement ..... FSS 2097
Ridgeland Medical Laboratory, Ernest Villanueva ..... MMF 426
Riis-Wald Medical Center, New York City ..... FAP 27
Roberts, Pvt. James A., Senate investigator ..... FAP 20, 26, 86
Robins, Edith G., quote ..... ADF 16, 25, 63
Robinson, Mr., Chicago Medical Laboratory ..... MMF 426
Rochelle, Robert, Memphis (Tenn.) Senior Citizens Service, letters ..... FSS 2191
Rohatyn, Felix, Municipal Assistance Corp ..... FAP 111
Romano, Frank C., Jr., First Ipswich Co., Inc., letter ..... NHF 109
Rosen, Dr. Ellen ..... FAP 85
Rosen, Dr. Alan, 80 Delancey Medical Center ..... FAP 82
Rosenberg, Dr. Jay, 80 Delancy Medical Center ..... FAP 84
Rosenblum, Dr. Marc ..... RCV 1, *85*
Quote, employment of elderly *88*
"Recession's Continuing Victim: The Older Worker," a working paper ..... RCV 1

NOTE: See page 223 for guide to code abbreviations.

Rosenthal, Julian B., NRTA/AARP *160*
Rosner, Henry, NYC Department of Social Services ..... FAP 17
Rossman, Dr. Isidore, quote ..... ADF 28
Ross, Beulah, Memphis, Tenn., statement ..... FSS 2179
Rossville (Tenn.) Poor People's Health Center, Dr. Erika K. Voss, statement ..... FSS 2162
Roule, Abbie J., Memphis, Tenn., statement ..... FSS 2177
Rubin, Melvin, Narco Freedom, Inc ..... FAP 75
Rugby Funding Ltd ..... FAP 16
Rural America defined *118*
Ryder, Dr. Claire, HEW ..... PHH 56

S

Sack, Cyril, Mermaid Medical Building Realty Corp ..... FAP 66, 70
Salt Lake Community Nursing Service, Maxine A. Thomas, letter ..... PHH 253
San Francisco Home Health Services, Hadley D. Hall, statements ..... PHH 130, 135, 150
Schroeder, Rep. Patricia, letter ..... PHH 252
Schweiker, Senator Richard S., statement ..... L–T 3446
Semple, J. Brooks, fire protection consultant ..... NHF 111
Senior Citizens of Rhode Island Action Group:
  Denis, Emile, statement ..... FSS 2127
  Winn, Charles, statement ..... FSS 2103
Semmel, Herbert, Center for Law and Social Policy, statement ..... PHH 141, 144
Senior Citizens Advocate Center, operation described *197*
Senior Group centers:
  Participants, characteristics ..... ADF 34
  Programs, origin, growth ..... ADF 32
  Study of, selected tables ..... ADF 103
Senior Information and Referral Service, Inc., Kingsport, Tenn., Cathy Davis, statement ..... FSS 2183
Shakin, Dr. Sholom, 80 Delancy Medical Center ..... FAP 82
Sharry, John, National Fire Protection Association ..... NHF 72
Shaw, Clifford, Cranston, R.I., statement ..... FSS 2078
Sheik, Dr. Jamshid ..... FAP 75
Sheinbach, Gerald, SSA ..... PHH 63
Sherman, William, *New York Daily News*, medicaid fraud probe ..... FAP 83, 94
Sherrod, Dr. Theodore, University of Illinois, quote, illness characteristic *106*
Sica, Dr. Albert J., letter to Senator Frank E. Moss ..... FAP 257
Silverstein, Harold H., Action Coalition of Elders, Pittsburgh (Pa.), statement ..... L–T 3439
Simon, John:
  GAO cooperation cited ..... MMF 294
  Illinois Department of Public Aid, statement ..... MMF 324
  Illinois Governor's Medical Payments Task Force ..... MMF 235, 249, 294, 298, 324, 347
Simos, Mr., Claremont Laboratory ..... MMF 427
Skinner, Samuel K., U.S. attorney *31*
Slavens, Gerald, Illinois Department of Public Aid ..... MMF 241, 320
Smith, John B., Medical Personnel Pool of America, Inc., statement ..... PHH 83
Spangenberg, Robert, Massachusetts Bar Association, quote, elderly unaware of SSI *194*
Social Security:
  Benefits:
    Automatic cost-of-living increase *10*
    Average cash, graphs ..... TSS 15
    Decoupling supported *17*
    Inadequate *2*
    Increases, table *2*
    Payment directly to nursing homes ..... PHH 36
    Race and sex, table *136*
  Blacks underrepresented *135*

NOTE: See page 223 for guide to code abbreviations.

Social Security—Continued
Carter versus Ford proposals 15
Committee findings and recommendations 21
Credits required for eligibility ..... TSS 14
Disability insurance protection, eligibles ..... TSS 10
Earnings limitation unfair ..... FSS 2154, 2157, 2173
Elderly, special price index needed 9
Financing deficits, cause 17
Financing problems 14
Fund deficit, causes 14
General revenue financing ..... FSS 2152
Rejected 17
House Ways and Means Committee, actions 16
Medicare:
Automatic eligibility ..... TSS 11
Hospital insurance protection ..... TSS 11
Supplementary medical insurance protection ..... TSS 12
Municipalities:
Withdraw from system, factors to consider, recommendations ..... TSS 22, 28
Withdraw from system, reasoning ..... TSS 19
Nursing Homes, patient accounts mismanaged ..... PHH 36
Protection, value of 19
Statement by Senator Dick Clark ..... TSS 9
Retired couple budget, table 3
Retirement:
Insurance protection ..... TSS 13
Staff plans, benefits exemplified ..... TSS 17
State and local government employees covered, statistics ..... TSS 3
State and local governments terminate, reasons ..... TSS 6
Survivors insurance protection, eligibles ..... TSS 9
Termination of coverage by State and local governments, reasons, effect 18
Social Security Administration:
Benefits, overpayment and collection ..... FSS 2115
Independent agency recommended 20
New York City, withdraw from system ..... TSS 1
Part-time employment, limitations ..... FSS 2120
Sheinbach, Gerald ..... PHH 63
Social Security Act:
Adult day facilities financing 37
Social Security Administration Act (S. 388), provisions enumerated 20
Social Security Cost-of-Living Improvement Act (S. 1992) 9
Somerville-Cambridge (Mass.) Home Care Corp., Lewis M. Levenson, statement ..... ILR 191
Spangenberg, Robert, ABT Associates, statement ..... ILR 168
Springfield (Mass.) Home Care Corp., James P. Piscioneri, letter ..... ILR 196
St Germain, Representative Fernand J. (R.I.):
Statement ..... FSS 2073
Staff Builders, James Terence Prendergast, statement ..... PHH 157
Staples, Laura, Illinois Governor's Office of Special Investigations, threat delivered ..... MMF 244, 250, 322
Charge refuted 383
Starr, Janet E., Coalition for Home Health Service in New York State, statement ..... PHH 118
State agencies on aging:
Developments 178
Innovative programs 181
Health programs 182
Legal services 182
Legislative actions 185
Nursing home activities 186
Title XX agreements, use of funds 180

NOTE: See page 223 for guide to code abbreviations.

"Steering" defined ..... FAP 18
Stevenson, Leon, NRTA/AARP, statement ..... FSS 2155
Stone, Robert, New York State Department of Education ..... FAP 69
Stultz, Evelyn, Erwin (Tenn.) Senior Citizens Center, statement ..... FSS 2187
Subcommittee on Health and Long-Term Care, Select Committee on Aging, U.S. House of Representatives, report ..... FAP 203
Sugarman, Jule M., letter to Senator Frank E. Moss ..... FAP 279
Supplemental Security Income:
Administration difficulties *143*
Benefits:
Detrimental effects *8*
Inadequacy of *7*
Minorities, by race, table *135*
Distribution, statistics *6*
Committee findings and recommendations *21*
Cost-of-living increase *11*
Disaster assistance amendments *176*
Efforts to improve *9*
Enumeration *11*
Elderly, eligibility, many unaware *13, 194*
Outreach program needed ..... FSS 2080
Outreach program, shortcomings *13*
Overpayments, underpayments, inadequate information *144*
Railroad Retirement Board to supply information *145*
Status report, tables *144*
Veterans' Administration to supply information *145*
Svahm, John A., letter to Senator Frank E. Moss ..... PHH 176

T

Talmadge, Sen. Herman E., medicare, medicaid fraud legislation introduced *32*
Tarter, Dr. Roger, Narco Freedom, Inc ..... FAP 74
Taxes:
Committee findings and recommendations *169*
Elderly, protect from overpayment, itemized deductions listed ..... OIT 1
Elderly, relief advocated ..... FSS 2106
Real estate:
Elderly relief program *54, 185*
Elderly relief programs by State, map *55*
Tax reform, changes enumerated *166*
Volunteer tax consultant training *168*
Tax Reform Act of 1976 ..... *166*
Taylor, Beth, New England Elderly Demand Society, statement ..... FSS 2104
Taylor, Evelyn, Memphis, Tenn., statement ..... FSS 2165
Taylor Medical Center, Robert C ..... FAP 46
Telephone; elderly, necessity of, cost ..... FSS 2110
Tennessee Commission on Aging, Dr. William E. Cole, statement ..... FSS 2153
3108 Mermaid Drug and Surgical Corp ..... FAP 70
3653 Broadway Pharmacal ..... FAP 71
Thomas, Maxine A., Salt Lake Community Nursing Service, letter ..... PHH 253
Thompson, James T., U.S. attorney ..... MMF 300
Tigar, Nancy, National League for Nursing, statement ..... PHH 108
Tomasso, Susan, West Warwick, R.I., statements ..... FSS 2114, 2135
Trager, Brahna, Adult Day Facilities for Treatment, Health Care, and Related Services, a report ..... ADF 1
Quote, adult day facilities *36*
Trainor, James L., Illinois Department of Public Aid ..... MMF 235, 238, 291
TransCentury Corp., Adult day care in the U.S., tables ..... ADF 58
Transportation:
Committee findings and recommendations *101*
Elderly:
Administration on Aging actions *93*

NOTE: See page 223 for guide to code abbreviations.

Transportation—Continued
Elderly—Continued
Special needs ADF 40
Supply inadequate FSS 2085, 2162
Elderly and handicapped:
Equal right to *95*
Local programs *99*
Handicapped, barriers *165*
Rural elderly, needs emphasized *94, 119*
Rural, funding *119*
Section 16(b)(2), delays in implementing *94, 119*
S. 682 defeated *94*
State activities *188*
Tucson experience, the ADF 40
UMTA paratransit policy *98*
UMTA transbus specifications *96*
Transportation, Department of, Public Interest Law Center of Philadelphia, class action suit *96*
Trautman, Don, National Association of Home Health Agencies PHH 146
Triebel, Dr. William, Mary Scranton Clinic FAP 74, 174
Tritendi, Rose, Providence, R.I., statement FSS 2109
Trivedi, Mr., Westlawn Clinical Laboratory MMF 421, 440
Tsongas, Representative Paul E., statement ILR 144
Turner, Rex C., Savannah, Tenn., statement FSS 2169

U

Urban Mass Transportation Authority:
Biaggi amendment, excerpt *95*
Paratransit policy *98*
Public Interest Law Center of Philadelphia, class action suit *96*
Section 16(b)(2), delays in implementing *94, 119*
Transbus specifications *96*
Williams amendment defeated *94*
Unemployment, elderly:
Duration table *87*
Suffer most *85*
Tables, by age and sex RCV 2
Unihealth Services Corp., Richard P. Brown, letter PHH 239
Statements PHH 81, 95
United Kingdom, day hospitals in ADF 63
United Medical Laboratory FAP 46
Pedgrift, Judy MMF 428, 436
U.S. Conference of Mayors, aging activities *189*
"Upgrading" defined FAP 18
Upjohn Homemakers Home & Health Care Services, Inc., Edward J. Wilsman, statements PHH 76, 89, 226
Utilities:
Elderly, rate increase, effect FSS 2158, 2176
Lifeline rates established *185*
Natural gas price increase *150*
Rates increase, effect on elderly FSS 2109

V

Vermont legal aid program ILR 180
Vescera, Vincent, Providence, R.I., statements FSS 2089, 2135
Veterans' Administration, SSI, cooperation with *145*
Villanueva, Ernest, Ridgeland Medical Laboratory MMF 426
Virginia Citizens Consumer Council, Inc., et al., drug price advertising suit *156*
Visiting Nurses Association PHH 77
Visiting Nurse Service of New York:
Cost per admission, table PHH 114
Letter PHH 257
Statement PHH 111

NOTE: See page 223 for guide to code abbreviations.

Von Solbrig Hospital, Chicago:
Conditions described ---- MMF 67
Medicaid fraud alleged ---- MMF 67
Surgery, performed unnecessarily ---- MMF 68
Chicago Tribune articles ---- MMF 110
Voss, Dr. Erika K., Rossville (Tenn.) Poor People's Health Center, statement ---- FSS 2162

W

Wagners, Dr. Sara B., Senior Groups Centers, study, selected tables ---- ADF 103
Walker, Gov., Dan, State of Illinois, letter ---- MMF 289
Wall, Gerald D., Boston Council of Elders, legal services programs, letter ---- IRL 171
Statement ---- IRL 171
Waller, Lucille, Memphis, Tenn., statement ---- FSS 2172
Walsh, Norma, Boston, statement ---- ILR 187
Walsh, Robert, HEW, letter ---- FSS 2134
Ware, Flora, Providence, R.I., statement ---- FSS 2124
Warner, Dr. George, New York State Health Department, statement ---- PHH 29
Warwick, R.I.:
Community action program:
Dolan, Elizabeth, statement ---- FSS 2129
Doyle, Beatrice, statement ---- FSS 2128
Geriatric Day Care Center, brochure ---- FSS 2139
Washington Park Medical Center, New Jersey ---- FAP 31
Washington State agencies on aging, plan ---- *184*
Waxman, Representative Henry A., quote, FTC funeral rule ---- *159*
Weiner, Gertrude K., Greater Boston Legal Services, statement ---- ILR 202
Weikel, Dr. Keither, HEW, statement ---- PHH 48
Welfare; elderly; effect on ---- *6*
Westlawn Clinical Laboratory:
Khan, Riaz ---- MMF 420, 428
Trivedi, Mr ---- MMF 421, 440
White House Conferences on Aging, midway, progress cited ---- *199*
Whiteman, Michael, letter to Senator Frank E. Moss ---- FAP 280
Wilkins, S. Everett, Providence, R.I., letter ---- FSS 2131
Williams, Senator Harrison A.:
Quotes:
LEAA funds ---- *125*
New housing programs ---- *56*
S. 662 defeated ---- *94*
Statement ---- MMF 7
Wilsman, Edward J., Upjohn Homemakers Home and Health Care Services, Inc., statements ---- PHH 76, 89, 226
Wimmer, Jay, Salt Lake City, Utah ---- PHH 151, 162
Wincrest Nursing Home:
Hurwitz, Dr. Paul ---- NHF 12
Pollard, Rev. William, statement ---- NHF 21
Wincrest Nursing Home fire:
Report ---- NHF 326
Gage-Babcock & Associates, Inc., report ---- NHF 89
Winn, Charles, Senior Citizens of Rhode Island Action Group, statement ---- FSS 2103, 2118
Winstanley, Dr. H. M. William ---- FAP 46
Winston, Dr. Ellen, National Council for Homemaker-Home Health Aide Services, statement ---- PHH 100

Z

Zipp, Alan, GAO ---- NHF 27

NOTE: See page 223 for guide to code abbreviations.